

SYSCO INJURY PROTECTION PLAN

(Amended and Restated Effective March 1, 2014)

SUMMARY PLAN DESCRIPTION

NOTICE TO ENGLISH SPEAKING ASSOCIATES: This booklet contains a summary in English of your plan rights and benefits under the Sysco Injury Protection Plan. If you have difficulty understanding any part of this booklet, or would like a copy in Spanish, contact the Risk Management Department at 1390 Enclave Parkway, Houston, Texas 77077, (281) 584-1390. Office hours are from 8:00 a.m. to 5:00 p.m., Monday through Friday.

AVISO A LOS ASOCIADOS QUE NO HABLAN INGLES: Este folleto contiene un resumen en inglés de sus derechos y beneficios bajo el plan, Sysco Injury Protection Plan. Si tiene dificultad en entender cualquier parte de este folleto o quiere obtener una copia del folleto en español, comuníquese con el Departamento de Manejo de Riesgo: Risk Management Department, 1390 Enclave Parkway, Houston, Texas 77077, (281) 584-1390. El horario de oficina es de 8:00 a.m. a 5:00 p.m., de lunes a viernes.

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Program Highlights

Why did Sysco Corporation start this Plan?

Sysco Corporation (the "Company") created the Sysco Injury Protection Plan (the "Plan") because we wanted a better administrative system for helping associates who are hurt at work.

We believe that the Texas Workers' Compensation System does not provide associates with the most efficient process for assisting those who sustain a work-related injury. Therefore, we have developed a program to provide more efficient, quality, and effective care than afforded by the current workers' compensation system. Many other businesses across Texas have adopted similar programs for their associates.

This approach has worked well for the Employer and its Texas associates in the past. With this updated program, effective March 1, 2014, we believe it can work even better now.

Who is covered by the Plan?

All Texas associates of Sysco Corporation and any other affiliated employer that participates in the Plan will be covered by this program. For the purposes of this Plan, these companies are individually and collectively referred to as "Employer."

How does the Plan affect me?

If you are injured on the job, the Employer will provide you with many benefits under the Plan, including paying for your covered medical care and making sure you receive a paycheck if you need to stay at home to recover. The Employer pays the entire cost of the Plan.

Is there a waiting period before my wage replacement benefits will begin?

No. Instead of the seven-day waiting period that is required by Texas Workers' Compensation, the Plan starts replacing your wages with a paycheck from the first full day that you miss work.

What are some of the requirements of the Plan?

All accidents and injuries will need to be reported immediately or by the end of the workshift for the date of the Injury or accident. ***You will not get in any trouble for reporting! In fact, your injury might otherwise get worse, and we want you to receive the medical care you need.***

To receive Plan benefits, you may only use physicians, hospitals and clinics that have been approved by the Claims Administrator. These approved physicians and approved facilities have been chosen for their ability to provide occupational injury medical services. ***If you are not satisfied with the decision or diagnosis by an approved physician, you can get a second medical opinion from another physician (as described later in this booklet).***

How are benefit payments handled?

Plan benefit decisions will be made, and any concerns that you have will be addressed, directly by the Employer and its designated adjusters. You will find this to be a much easier and faster process than working through the state system and individuals with whom you are not familiar. We expect to provide a better service when addressing the needs of our injured associates.

What if I am not satisfied with how my benefit claim is handled?

You have the opportunity to file an appeal with an Appeals Committee. On appeal, the Appeals Committee will conduct an independent review of the claim and you can submit additional information supporting payment of the claim.

What if I have other issues related to my injury?

This program includes dispute resolution procedures to resolve other injury-related disputes between you and the Employer quickly and fairly. Arbitration is a process in which a skilled, independent arbitrator (similar to a judge) hears both sides of the situation and then makes a final and binding decision.

What are the advantages of arbitration?

Protected Rights

Arbitration offers the same fundamental protections as a court of law. And the arbitrator, just like a judge or jury, may award you anything you might seek through a court of law.

Fast Decisions

When a problem is taken to court, it often takes years to conclude. During that time, your time, money and energy that could be better used are tied up with paying expensive legal fees and court costs, having delays and wading through endless paperwork. But with arbitration, hearings can often be scheduled within a month or so of your request and decisions can be reached in just a few months.

Fair Decisions

Courts hear all types of cases ranging from car accidents to divorces. Judges and juries do not specialize in solving work-related problems. But arbitrators do. More importantly, the arbitrator is objective and does not have any relationship with the Employer.

Does this Plan directly affect my health insurance or other benefits?

No. This Plan is a separate program from your health insurance and other benefits and applies only when injuries happen on the job.

When does this updated Plan take effect?

It is effective for all on-the-job injuries involving Texas associates that occur on or after March 1, 2014.

PLAN BENEFITS

Maximum Benefit Limit

Maximum amount for all benefits combined payable to you for an injury	\$500,000 per associate \$1,000,000 per occurrence
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Medical Benefits

Pays for care from approved health care providers if you are injured at work	100% of covered charges for up to 126 weeks
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Wage Replacement Benefits

Pays you weekly income if you need time at home to recover	Starting on the first full day of disability pays 100% of your "lost wages" for up to four weeks , then 85% for up to a total of 126 weeks
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Death Benefits

Provides payment to eligible beneficiaries if death occurs on the job	Up to \$500,000 (paid 20% down and remainder over 35 months)
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Burial Benefit

Provides reimbursement for burial expenses	Up to \$10,000
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Dismemberment Benefits

Provides a payment for loss or loss of use of a member of the body	Up to \$500,000 , based upon the severity of the injury (paid 20% down and remainder over 35 months)
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Please see the Program Detail section of this booklet for a more complete description of benefits, taxation issues, applicable exclusions, and limitations and requirements you must satisfy in order to receive benefits.

Case Study

How does the Plan work?

Take a look at the example below to see how the Plan's benefits might work if you have an injury.

Pat, who is a delivery associate, suffers a back injury. Pat, who earns \$1,000 a week, is not able to return to work until five weeks after the accident. Pat's total covered medical charges following the accident are \$3,000.

The Bottom Line

In this example, Pat would be eligible to receive **\$7,850** under the Plan.

Pat would receive:

- \$3,000 in Medical Benefits (100% of all covered medical charges)
- \$4,850 in Wage Replacement Benefits (100% of lost wages for the first four weeks, and 85% of lost wages for the remaining week of disability)

*Of course, **Pat's case is just an example** and might not be like your situation at all if you're injured on the job. You may be entitled to receive more or less benefits than those provided in this example, depending on the severity of your injury and other factors.*

This example simply illustrates what a difference having great benefit protection under the Plan can make in certain situations.

Reporting an Injury

What should I do if I am injured on the job?

The Employer has set up procedures to make sure you receive treatment for your injuries in an efficient, quick manner. By following these and other Plan rules, your covered medical bills will be paid and your paycheck will continue even if you need to stay at home to recover. More detailed information on these procedures is found later in this booklet.

1. Report Your Injury Immediately

You must report your injury to your Supervisor, Safety Manager, Human Resources Manager, Risk Management Manager or Health Services no later than the end of your workshift for the date of the Injury. Don't wait! Your injury might get worse and we want to help you.

2. Fill Out an Accident Report

You must complete a report that provides details of the incident that resulted in your injury within 24 hours of the time your Injury is reported. You and the Employer will then work together to investigate your claim.

3. Use an Approved Physician or Approved Facility for Medical Treatment

In order to receive injury benefits, you must use physicians, hospitals, clinics and other health care providers and facilities that have been approved by the Plan's Claims Administrator. You must also receive your first medical treatment from an Approved Physician or Approved Facility within 14 days after the date of your injury.

4. Submit to a Drug and/or Alcohol Screen

If you are injured on the job, you will be required to submit to a drug and/or alcohol test, in accordance with your applicable operating company's substance abuse policy.

5. Follow the Doctor's Orders

You must follow the approved physician's instructions and keep all scheduled appointments with health care providers.

6. Welcome Back!

You must keep the Employer informed about your return to work status. We will look forward to welcoming you back as soon as the treating physician issues a medical release saying you are able to return to full or Modified Duty.

PROGRAM DETAIL

INTRODUCTION

Sysco Corporation (the "Company") is committed to providing loss of income protection and helping you pay medical expenses that might otherwise present a financial burden to you if you are injured on the job. To accomplish this, the Company has implemented a benefit program called the Sysco Injury Protection Plan (the "Plan"). **The Plan has been adopted for the benefit of the Texas associates of Sysco Corporation and any other affiliated employer that participates in the Plan (individually and collectively referred to as the "Employer").** This booklet has been prepared to help you understand your benefits under the Plan. Please read it carefully.

If any conflict arises between the information contained in this booklet and the provisions of the formal Plan document, the Plan document will control. Certain terms used in this booklet are capitalized and defined in the DEFINITIONS section of this booklet.

Except as otherwise provided in this booklet, benefits and other requirements described in this booklet are effective for all covered Injuries occurring on or after March 1, 2014.

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

The following notice is being provided as required by Texas law:

COVERAGE: Sysco Corporation does not have workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. However, a non-covered (non-subscribing) employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits for a work-related injury or occupational disease. In addition, you may have rights under the common law of Texas should you have an on the job injury or occupational disease. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY VIOLATIONS HOTLINE: The Division has established a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

This notice also applies to all Employers participating in the Plan.

Your Injury Benefit Plan: The Employer **DOES PROVIDE** to all Texas associates, without cost, the Plan described in this booklet.

Our Safety Program: Our success largely depends upon you following all of our safety rules and procedures and immediately notifying your supervisor **first** of any unsafe working condition, safety violation or on-the-job injury, no matter how minor. As mentioned above, you will not be suspended, terminated, or discriminated against because you in good faith report an unsafe working condition, on-the-job injury or potential occupational health or safety violation.

ELIGIBILITY

You automatically become a participant in the Plan if you are a Texas associate of a participating operating company or Sysco Corporation and your employment with the Employer is principally located within the State of Texas. You must be a person who is employed in the regular business of, and receive your pay by means of a salary, wage or commission directly from, the Employer and for whom the Employer files a Form W-2 with the Internal Revenue Service. This Plan does not cover an independent contractor or third-party agent.

HOW THE PLAN WORKS

Medical Determinations and Treatment

As explained further below, in order to receive any benefits under this Plan, all medical care must be **pre-approved by the Claims Administrator** and furnished by or under the direction of an **Approved Physician or Approved Facility (acting within the scope of their license)**, unless provided in connection with Emergency Care as described below. This means you must communicate with your Company's designated Claims Administrator regarding your request for medical treatment. If you do not know who the Claims Administrator is for your Company, you should contact Health Services or your Risk Management Manager.

Any list of Approved Physicians and Approved Facilities will be furnished to you, without charge, as a separate document. The Claims Administrator reserves the right to add to, delete from, or otherwise amend any list of Approved Physicians or Approved Facilities at any time. **No Approved Physician or Approved Facility is an agent of the Employer. Although benefits under this Plan are conditioned on your use of only Approved Physicians and Approved Facilities, you remain entitled to seek any medical care you deem appropriate from any provider of your choice at your own expense. In addition, the Plan is not intended to affect your relationship with your health care providers. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of you and your attending Approved Physician and other health care providers based on their independent judgment for the provision of health care.**

For purposes of this Plan, all determinations relating to your physical condition and the payment of benefits (for example, inability to return to work or results of a prior injury) must be made by an Approved Physician. You must follow fully and completely the advice of, and the course of medical treatment prescribed by, the treating Approved Physician, and must keep all scheduled appointments to fulfill the prescribed medical treatment plan. The Claims Administrator will have the right to require you to be examined or reexamined by an Approved Physician as often as they determine to be reasonably necessary or appropriate while you are receiving or claiming benefits under the Plan.

Procedure In Event Of Injury

- **You must notify your** Supervisor, Safety Manager, Human Resources Manager, Risk Management Manager or Health Services **immediately after being injured at work, no matter how minor the Injury appears to be (including any disease exposure).** For an Injury due to an Accident or for a known exposure to an Occupational Disease, verbal notice must be provided **by the end of the workshift for the date of the Injury.** For an actual Injury due to Occupational Disease or Cumulative Trauma, verbal notice must be provided 24 hours after being medically diagnosed with a work-related Injury, or within 72 hours after you should have known of the work-related Injury, whichever is earlier. You must also submit a written report to your Supervisor within 24 hours after the Injury is reported.
- **For purposes of an Injury that involves an Accident, the date of the Injury shall be the date of the Accident resulting in the Injury.** For purposes of an Injury that involves an Occupational Disease or Cumulative Trauma, the date of the Injury shall be the earlier of (1) the date that the damage, harm or symptoms of the Occupational Disease or Cumulative Trauma were first known (or should have been known) to you, or (2) the date that an Approved Physician medically diagnosed you with an Occupational Disease or Cumulative Trauma.
- With respect to an Injury due to Occupational Disease or Cumulative Trauma, if the Employer has purchased an insurance policy, the purpose of which (in whole or in part) is to pay Plan benefits to a participant or reimburse the Employer for Plan benefits, then the notice of Injury from Occupational Disease or Cumulative Trauma must in all events be provided not later than 35 months after the end of the policy period.
- **You must receive medical care from an Approved Physician or Approved Facility.** You may use a non-approved physician or facility (and still be eligible to receive benefits under this Plan) **only** if the following requirements are satisfied:
 - **First**, the treatment must be for Emergency Care (as described further in the MEDICAL BENEFITS section of this booklet);

- **Second**, you provide notice to the Claims Administrator of such Emergency Care within the later of 24 hours after your receipt of such care or the next business day; and
 - **Third**, after receiving primary treatment in Emergency Care, subsequent treatments must be provided by, or at the direction of, an Approved Physician or Approved Facility.
- **You must receive your first medical treatment from an Approved Physician or Approved Facility within 14 days after the date of your Injury.** If necessary, the Claims Administrator will assist you in arranging for appropriate treatment.
 - **You must submit to alcohol and/or drug testing, in accordance with the applicable Employer's substance abuse policy, at the time of your initial medical treatment.** You must either provide the Employer with this alcohol and drug testing information or authorize the Employer to gain access to this information.
 - **You must obtain pre-approval for all medical care from the Plan's Claims Administrator.** You do not have the right to select and have the Plan pay for your choice of a primary care provider or provider of specialty medical care, even if such provider is an Approved Physician or Approved Facility.
 - **You must also follow the procedures described below in the REQUESTING BENEFITS section and comply with the requirements of the CONTINUING BENEFITS section of this booklet.**

Funding

The Employer currently pays the entire cost to provide your coverage under this Plan and pays Plan benefits solely out of the general assets of the Employer. The Employer has the right, but no obligation, to obtain insurance contracts to provide funds to the Employer that can be used by the Employer to pay all or any portion of a benefit under the Plan; but no benefits under the Plan are guaranteed under any contract or policy of insurance and the Employer will be solely responsible for the payment of claims under this Plan. If the Employer has purchased an insurance policy, the purpose of which (in whole or in part) is to provide funds to the Employer for Plan benefits or that may be used to reimburse the Employer for Plan benefits, then:

- **benefit payments under this Plan shall not be payable or shall immediately cease in the event that benefits coverage is not available to the Employer or ceases under such policy for any reason; and**
- no such insurance policy proceeds shall be considered "plan assets" for purposes of ERISA. Policy proceeds shall constitute a part of the general assets of the Employer. Any such insurance policy shall be owned by, and all amounts under the policy shall be payable to the Employer, and you shall not have any interest in, or right to, any amounts payable under the policy (even though certain benefit

payment, reporting or other requirements of this Plan may relate to requirements of such insurance policy).

COVERED AND NON-COVERED INJURIES

Covered Injuries

The Plan pays benefits only on account of an **"Injury."** An "Injury" means damage or harm to the physical structure of the body resulting from either:

- an **"Accident"** (which means an event involving factors external to you that --
 - was unforeseen, unplanned, and unexpected;
 - occurred at a specifically identifiable time and place;
 - occurred by chance or from unknown causes; and
 - resulted in physical injury to you);
- an **"Occupational Disease"** (which means a condition marked by a pronounced deviation from your normal healthy state arising out of your assigned duties in your Course and Scope of Employment. Occupational Disease includes other diseases or infections that naturally result from the work-related disease. Occupational Disease does not include ordinary diseases of life to which the general public is exposed outside of your assigned duties in your Course and Scope of Employment); or
- **"Cumulative Trauma"** (which means damage to the physical structure of your body occurring as a result of rapid, repetitious, physically traumatic activities that occur in the Course and Scope of Employment. The term "Cumulative Trauma" does not mean fatigue, soreness or general aches and pain that may have been caused, aggravated, exacerbated or accelerated by your Course and Scope of Employment. No benefits will be payable with respect to Cumulative Trauma unless you have completed at least 180 days of continuous, active employment with the Employer and have been regularly engaged in the Course and Scope of Employment with the Employer involving rapid, repetitious, physically traumatic activities).

Any such damage or harm must occur or arise during, and directly and solely result from, the Course and Scope of Employment by the Employer (see the DEFINITIONS section of this booklet). In order to be subject to the provisions of this booklet, **the date of the Injury must be on or after March 1, 2014.**

Any provision of this Plan to the contrary notwithstanding, if the Employer has purchased an insurance policy as described above, the purpose of which (in whole or in part) is to pay Plan benefits to a participant or reimburse the Employer for Plan benefits, then:

- the Accident must have occurred during the policy period;
- your last day of last exposure to the condition causing or aggravating any Occupational Disease must have taken place during the policy period; or
- your last day of last exposure to the condition causing or aggravating the Cumulative Trauma must have taken place during the policy period.

All injuries relating to (1) an Accident or related series of Accidents, (2) exposure to an environmental or physical hazard that causes Occupational Disease, or (3) rapid, repetitious, physically traumatic activities that result in Cumulative Trauma, will be considered a single Injury.

Types of Non-Covered Injuries

The term "Injury," as used in this booklet, does not include:

- Any strain, degeneration, damage or harm to, or disease or condition of, the eye or musculoskeletal structure, or other body part resulting from:
 - use of a video display terminal or keyboard;
 - poor or inappropriate posture;
 - the natural results of aging;
 - osteoarthritis, arthritis, or degenerative process (including, but not limited to, degenerative joint disease, degenerative disc disease, degenerative spondylosis/spondylolisthesis and spinal stenosis); or
 - other circumstances prescribed by the Claims Administrator which do not directly and solely result from your Course and Scope of Employment;
- Factors to which the general public is exposed;
- Diagnostic labels which imply generalized musculoskeletal aches and pains in the absence of any demonstrable primary pathophysiology, such as Fibrositis, Fibromyalgia, Myofascial Pain Syndrome, Myositis, or Chronic Fatigue Syndrome;
- Except to the limited extent provided under the section of this booklet entitled "Medical Services and Supplies Requiring Specific Approval in Writing or by Electronic Notice," any mental injury, emotional distress, mental trauma or similar injury to your mental or emotional state, including, without limitation:
 - any physical manifestations resulting from such mental or emotional state; and
 - any mental or emotional damage or harm that arises primarily from a personnel action, including, but not limited to, a transfer, promotion, demotion or termination of employment or other disciplinary action;
- Ptomaine or bacterial infection, except pyogenic infection which occurs with and as a result of an accidental cut or wound;

- Damage or harm resulting from airborne contaminants not commonly found in the Employer's normal working environment, including, but not limited to, pollen, fungi, and mold;
- Damage or harm resulting from job stress;
- Any heart attack, stroke, or aneurysm (an "attack"), unless --
 - the attack can be identified as –
 - occurring at a definite time and place; and
 - caused by a specific event related to, and occurring in, the Course and Scope of Employment;
 - the preponderance of the medical evidence regarding the attack indicates that your work rather than the natural progression of a preexisting heart condition or disease was a substantial contributing factor of the attack; and
 - the attack was not triggered solely by emotional or mental stress factors, unless it was precipitated by a sudden work-related stimulus;
- Hernia, unless inguinal and/or umbilical hernia that -
 - appeared suddenly and immediately following the Injury;
 - did not exist in any degree prior to the Injury; and
 - was accompanied by pain; or
- Any Preexisting Condition, except to the limited extent (if any) that an Approved Physician clearly confirms an identifiable and significant aggravation (incurred in the Course and Scope of Employment) of a Preexisting Condition; provided, however, that
 - coverage for such aggravation will be provided only if and to the extent that the Approved Physician –
 - confirms that the Preexisting Condition has been previously repaired or rehabilitated; and
 - prescribes services or supplies that are medically necessary to treat such aggravation and likely to return you to pre-Injury status; and
 - no coverage will be provided if the Preexisting Condition was a major contributing cause of the Injury.

Non-Covered Injury Circumstances

Furthermore, no benefits will be payable under the Plan if:

- you are not an associate of the Employer or your employment is not principally located in the State of Texas;
- the Injury occurred while you were in a state of intoxication or had otherwise lost the normal use of your mental or physical faculties as a result of the use of a drug or alcohol. For this purpose, you will be considered to have been in a state intoxication at the time of the Injury if the drug or alcohol test required by the Employer finds a violation of the applicable Employer's substance abuse policy;
- the Injury is treatable by medical care that is reasonable and of a form that an ordinary prudent person in the same or similar circumstances would undergo, and you have not availed yourself of such treatment;
- the Injury was caused by your willful intention or attempt to injure yourself or another person, whether you were sane or insane;
- the Injury occurred while you were employed in violation of any law;
- your horseplay, scuffling, fighting, or similar inappropriate behavior was a proximate cause of the Injury;
- your long-term cell phone use, or second-hand smoke was a proximate cause of the Injury;
- the Injury was incurred while you were "on suspension," "laid off" by the Employer, on leave of absence for any other reason, or otherwise outside of the Course and Scope of Employment;
- the Injury arose out of an act of a third person intended to injure you because of personal reasons and not directed at you as an associate or because of your employment;
- the Injury arose out of your participation in an off-duty recreational, social or athletic activity not constituting part of your work-related duties, except where these activities are expressly required in writing by the Employer (more than an invitation or request to participate or attend);
- the Injury arose out of an act of God, unless your employment exposes you to a greater risk of Injury from an act of God than ordinarily applies to the general public;
- the alleged Injury is feigned or an attempt to defraud the Employer;
- the Injury arose out of your participation in:
 - a riot or act of civil disturbance;
 - a war, declared or undeclared;
 - any act of war or terrorism;
 - any illegal act;

- a felony or an assault, except an assault committed in defense of the Employer's business or property; or
 - service in the military of any country or any civilian non-combatant unit serving with such forces;
- any damage or harm arising out of the use of or caused by --
- asbestos, asbestos fibers or asbestos products; or
 - the hazardous properties of nuclear material or biological contaminants;
- the Injury arose out of your participation in the commission, or attempted commission, of any crime;
- the Injury occurred while you were traveling or flying in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation if you are:
- flying in any aircraft that is rocket propelled;
 - flying in any aircraft used for aerobatics, racing or an endurance test, crop dusting, seeding, fertilizing, or spraying, fighting a fire, any exploration or pipe or power line patrol, the pursuit of animals or birds, aerial photography, banner towing or skywriting or any test or experimental usage;
 - flying when a special permit or waiver from the proper authority has to be issued;
 - riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
 - performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
 - riding as a passenger in an aircraft owned, leased, or operated by the Employer;
- the Injury did not occur during your Course and Scope of Employment; or
- the Injury was not timely reported (or requested information was not timely provided) in accordance with the timeframes specified in the REQUESTING BENEFITS section of this booklet.

WAGE REPLACEMENT BENEFITS

When Wage Replacement Benefits Begin

- **Total Disability.** From the first full day that you become Totally Disabled due to a covered Injury, the Plan shall pay Wage Replacement Benefits equal to 100% of your Pre-Injury Pay for the first four weeks of Total Disability, and 85% of your Pre-Injury Pay thereafter.
- **Partial Disability.** From the first full day you become Partially Disabled, the Plan shall pay Wage Replacement Benefits equal to 100% of the portion of your Pre-Injury Pay that you are unable to earn for the first four weeks of Partial Disability, and 85% of the

portion of your Pre-Injury Pay that you are unable to earn thereafter (due to the Approved Physician's restrictions) while working Modified Duty..

- If you have a Partial Disability and are released to Modified Duty, but (i) the Employer has no Modified Duty position available, and (ii) an Approved Physician has not assigned permanent restrictions and released you to any other gainful employment, then you will be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified above under "Total Disability."
- If you have a Partial Disability and have made a good faith effort to comply with the treating Approved Physician's instructions and carry out your responsibilities in the Modified Duty position, but you are either:
 - again determined by an Approved Physician to be Totally Disabled, or
 - the Modified Duty position ceases to be available (for example, the position reaches its maximum duration) and an Approved Physician has not assigned permanent restrictions and released you to any other gainful employment;

then you will be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified above under "Total Disability."

The Employer's ability to provide a Modified Duty position while you are under work restrictions determined by the Approved Physician does not imply or create a permanent Modified Duty position for the purposes of the American with Disabilities Act ("ADA").

- **Payment Terms and Other Limitations.** An Approved Physician must make the determination regarding whether you are Disabled, except to the extent that such determination is made in conjunction with Emergency Care as determined by the Claims Administrator. Wage Replacement Benefits are calculated on a weekly basis, and paid on regular paydays. Payments for portions of a week shall be prorated. Only your normal, scheduled workdays shall be considered in calculating benefits (based upon your employment status as of the date of Injury). Wage Replacement Benefit payments shall be reduced as described in the "Offset For Other Benefits" section of this booklet.

When Wage Replacement Benefits Cease

Wage Replacement Benefits will continue until the earliest of:

- the expiration of 126 weeks from the date of the Injury. This 126-week maximum period for Wage Replacement Benefits is calculated continuously from the date of the Injury, regardless of whether or not you qualify as Disabled at all times during such period or receive Wage Replacement Benefits continuously throughout such period;

- the date you are determined by the treating Approved Physician to no longer be Disabled, without regard to whether you return to regular or Modified Duty on that date;
- the date that the Maximum Benefit Limit is met;
- termination of all your employment with the Employer; provided, however, that this paragraph will not apply if termination of employment is solely due to -
 - application of a duration limit in the Employer's leave of absence policy, or
 - elimination of your employment position;
- the date you are placed in jail, are deported or detained by or at the request of any government agency or foreign government, have left the local area for an extended period of time, or are similarly unavailable for work; provided, however, that this paragraph shall operate to cease Wage Replacement Benefits only for such period of time that you are unavailable for work; or
- the date you reach Maximum Rehabilitative Capacity (as determined by an Approved Physician), or as otherwise provided under the CONTINUING BENEFITS section below.

Other Benefit Reductions

Wage Replacement Benefits are generally considered taxable income, and all appropriate amounts will be withheld. Also, amounts legally garnished may be withheld and appropriate Pre-Injury Pay deductions for such items as retirement plan contributions and insurance premiums will continue to be withheld unless you provide instructions to the contrary in accordance with applicable program rules and procedures.

DEATH BENEFITS

If you die as the direct and sole result of, and within 365 days of, an Injury, then the Plan will pay your Beneficiary a Death Benefit equal \$500,000; provided, however that this benefit amount shall be reduced to the extent necessary to avoid exceeding the Plan's Maximum Benefit Limit.

The Death Benefit will be paid to your Beneficiary as follows: (1) 20% will be paid in a lump sum cash payment as soon as administratively possible following your death; and (2) the remainder will be paid in 35 equal monthly installments (without interest) commencing on the first day of the month following the initial lump sum payment. Death Benefits will be in addition to Dismemberment Benefits, Wage Replacement Benefits and Medical Benefits payable with respect to any one Injury; provided, however, that no interest in future Dismemberment Benefits survives after your death if your Beneficiary then becomes entitled to Death Benefits under this Plan. In addition to the Death Benefits set forth above, the Plan shall reimburse reasonable burial expenses to any person who incurs liability therefore, up to \$10,000.

DISMEMBERMENT BENEFITS

If you suffer a loss described in the Schedule of Losses below as the direct and sole result of, and within 365 days of, an Injury, then the Plan will pay you an amount equal to the applicable percentage from the schedule below times \$500,000; provided, however that this benefit amount shall be reduced to the extent necessary to avoid exceeding the Plan's Maximum Benefit Limit. For example, if you suffer an Injury resulting in the loss of the sight in one of your eyes (as described below), you would generally be entitled to a Dismemberment Benefit of \$250,000 (50% x \$500,000).

The Dismemberment Benefit will be paid as follows: (1) 20% will be paid in a lump sum cash payment as soon as administratively possible following the date of loss; and (2) the remainder will be paid in 35 equal monthly installments (without interest) commencing on the first day of the month following the initial lump sum payment.

SCHEDULE OF LOSSES

<u>Loss of:</u>	<u>Benefit Amount:</u>
Both Hands	100%
Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Speech and Hearing	100%
One Hand	50%
One Foot	50%
Sight of One Eye	50%
Speech	50%
Hearing	50%
Finger or Toe (two joints)	10%
Finger or Toe (one joint)	5%

(a) If you suffer more than one Injury described above from any one Accident, related series of Accidents, or Occupational Disease exposure or Cumulative Trauma exposure only one of the applicable Dismemberment Benefits listed above, the largest single amount, will be payable with respect to such Accident or exposure.

(b) Total and permanent loss of use of a member of the body is the same as loss of such member. Prior to payment of the benefit, loss of use must be certified following the care of an Approved Physician for 12 straight months from the date the loss of use began. At the end of this time it must be medically determined by an Approved Physician that the loss of use is total and not reversible.

(c) Loss of Hand or Foot means the complete and permanent severance through or above the wrist or ankle joint. Loss of Sight means legally blind. Such loss correctable by surgery or lenses will not result in payment of a Dismemberment Benefit. Loss of Speech means the total and permanent loss of speech. Loss of Hearing means the total and permanent loss of hearing in both ears.

(d) The above-described loss of "Finger or Toe (two joints)" must be at or above the joint at the proximal end of the middle phalanx of the finger or toe; except that for the thumb or great toe, such loss must be at or above the metacarpophalangeal joint. The above-described loss of "Finger or Toe (one joint)" must be at or above the joint at the distal end of the middle phalanx of the finger or toe; except that for the thumb or great toe, such loss must be at or above the joint at the distal end of the proximal phalanx.

(e) Dismemberment Benefits shall be in addition to Wage Replacement Benefits and Medical Benefits; provided, however, that payment of Dismemberment Benefits will cease in the event of the death of the Participant which results in the payment of Death Benefits.

MEDICAL BENEFITS

Subject to the medical management and other provisions of this Plan, medical services and supplies that are approved by your Claims Administrator (referred to below as "Covered Charges") are covered at 100%, with no co-pays, deductibles or other out-of-pocket expense to you, provided that all applicable Plan requirements are satisfied. The service or supply must be medically necessary, based on the nature of the Injury, as and when provided, and (1) cure or relieve the effects naturally resulting from the Injury; (2) promote recovery; or (3) otherwise enhance your ability to return to or retain employment. Such services and supplies are also subject to the other medical management provisions of the Plan. Coverage also requires satisfaction of the following requirements:

First and Continuing Treatment

- The first Covered Charge must be received from an Approved Physician and incurred within 14 days following the date of your Injury (unless the Claims Administrator determines that good cause exists); and
- No further amount shall be considered a Covered Charge if you do not receive medical treatment from an Approved Physician or Approved Facility (or scheduled treatment with an Approved Physician or Approved Facility has not been approved by your Claims Administrator) for a period of more than 60 days. This section, however, shall not apply to any Covered Charge for testing and any follow up vaccination with respect to an Injury that involves a potential occupational exposure to a bloodborne pathogen.

Approved Provider and Pre-Authorization Requirements

The cost of a service or supply shall be a Covered Charge only if:

- **Treatment is (1) furnished by or under the direction of an Approved Physician or Approved Facility, acting within the scope of the Approved Physician's or Approved Facility's license, and (2) pre-approved by the Claims Administrator (except when your Claims Administrator determines that prior approval was impossible under the circumstances).** Such pre-approval may include authorization for multiple visits to an Approved Physician or Approved Facility, and must be in writing, or by electronic notice (except as otherwise specified below or in the Plan's claims procedures); or
- **Treatment is provided as Emergency Care and (1) your Claims Administrator receives notification of such Emergency Care within the later of 24 hours of your receipt of such care or the next business day; and (2) after receiving primary Emergency Care, subsequent treatments are provided by, or at the direction of, an Approved Physician or Approved Facility in accordance with the paragraph above.**

An Emergency Care determination solely relates to consideration of an exception to the Plan's approved medical provider requirements. "Urgent Care Claims" (as discussed in this booklet's claims procedures) may not arise to the level of involving Emergency Care. Any decision by you to seek treatment from an urgent care clinic or hospital emergency room does not necessarily involve Emergency Care. An Emergency Care determination shall be made within the sole administrative discretion of your Claims Administrator or Appeals Committee, with such advice and consultation from an Approved Physician as your Claims Administrator or Appeals Committee deems appropriate. If you obtain treatment from a non-approved health care provider and your Claims Administrator or Appeals Committee determines that your situation has not satisfied all of the above requirements, your claim for benefits will be denied.

Covered Medical Services and Supplies

Medical Services and Supplies That Can Be Verbally Authorized. Subject to the restrictions and limitations set out elsewhere in this booklet, Covered Charges that can be verbally authorized will include the cost of the following:

- **Approved Physician visits - at an Approved Facility (including charges for an emergency room), Approved Physician's office, or in the case of home health care, at your home, including second opinion services requested by the Claims Administrator, and charges for a registered nurse;**
- **Medical supplies approved by the treating Approved Physician, including the following:**

- Prescription drugs (generic, unless trade name drugs are requested by an Approved Physician) and over-the-counter drugs such as analgesics prescribed by an Approved Physician;
 - Blood and other fluids (other than allergy, insulin, and similar drugs) injected into the circulatory system (but only to the extent not available through any refund or allowance by a blood bank or similar organization);
 - Oxygen and its administration;
 - Upon the written advice or prescription of an Approved Physician and only if obtained from an Approved Facility, rental or purchase of a wheelchair, assisted breathing apparatus, or other mechanical equipment necessary for the treatment of respiratory paralysis, and similar internal or external durable medical equipment designed primarily for therapeutic purposes;
 - Surgical dressings, bandages, splints, casts, crutches, syringes, needles, trusses, and braces dispensed by an Approved Physician or Approved Facility; and
 - Other items approved by the Claims Administrator;
- Ambulance services - professional ground ambulance service, or if no other means of transportation can reasonably suffice to deliver the individual to the closest appropriate Approved Facility, air ambulance, regularly scheduled railroad, or airlines;
- Eyeglasses or contact lenses - one pair per Injury up to \$400, inclusive of professional office visit charges, but excluding routine eye examinations; and
- External hearing aid - up to \$600 per ear, inclusive of professional office visit charges.

Medical Services and Supplies Requiring Specific Approval in Writing or by Electronic Notice. Subject to the restrictions and limitations set out elsewhere in this Plan, Covered Charges shall also include the cost of the following so long as the Claims Administrator specifically approves such charges in advance and in writing or by electronic notice:

- Admission to an Approved Facility on an inpatient or outpatient basis, including semi-private room and board, ambulatory day surgery, anesthesia and its administration, and similar services;
- Diagnostic testing, including x-ray examinations, laboratory tests, MRI, CAT Scan, nuclear medicine, radiology and pathology (including interpretive services) and similar testing;
- Speech, occupational and physical therapy provided by an Approved Physician or a licensed speech therapist, licensed occupational therapist or licensed physical therapist; provided, however, that such services shall be subject to case management approval regarding the number of visits, the types, and amount of services provided during such visits;

- Inpatient rehabilitation services provided in a medical rehabilitation hospital; provided, however, that such services shall be subject to continued stay review by the Claims Administrator and case management approval regarding the types and amount of services provided;
- Limited or temporary pain management services (for example, epidural steroid injections), but not including pain management programs;
- Surgery that restores a reasonable, normal pre-Injury functioning;
- Services of a dentist or licensed oral surgeons - services for treatment and repair of broken teeth, fractures and dislocations of the jaw, or the replacement of teeth (excluding temporomandibular junction dysfunction services) when you seek treatment as soon as possible after the Injury;
- Home health care (with respect to physical needs only) up to 75 visits per Plan Year and up to eight hours per visit for the first two weeks of home health care and up to four hours per visit thereafter;
- Skilled nursing care, provided that an Approved Physician monitors your progress at least once during each 30-day period of confinement;
- Orthotics, arch supports, corrective shoes, special bras or girdles, corrective appliances, prosthesis, or any similar item;
- Organ and tissue transplant services not otherwise covered by some form of expense payment program, excluding the donor's transportation costs, organ procurement costs and the donor's surgical expenses;
- Charges for telephone consultations with you, your Representative, Approved Physicians or other health care providers;
- Mental health services (to the extent not otherwise covered by an Employee Assistance Program), but only when such services are provided for mental or emotional damage or harm resulting from you being the victim of, or witness to, a traumatic event occurring during your Course and Scope of Employment; and provided, that such services shall not exceed five visits with an Approved Physician or Approved Facility. This coverage will apply solely to Medical Benefits coverage and will not result in any payment of Wage Replacement Benefits or other benefits under this Plan;
- Services rendered primarily for training, testing, evaluation, counseling, or educational purposes; and
- Reasonable travel, meal and lodging expenses related to medical treatment that requires travel greater than 20 miles from your residence (one way) as interpreted by the Claims Administrator for application under this Plan and approved by the

attending Approved Physician. Mileage will be reimbursed at the Internal Revenue Service identified "Medical Purposes" rate, as periodically updated.

Non-Covered Medical Services and Supplies

While the Plan provides benefits for many medical expenses, the following expenses are **not** covered by the Plan:

- Charges incurred prior to your date of participation in the Plan, or prior to your date of Injury;
- Charges rendered after your Medical Benefits under this Plan terminate;
- Expenses which are not medically necessary, as determined by the Claims Administrator;
- Charges incurred more than 60 days after the date of the last Covered Charge (except as otherwise specified in this booklet);
- Expenses that exceed any fee schedule adopted by the Claims Administrator or the usual and customary charge for the same or similar treatment, services or supplies in your geographic area;
- Services or supplies payable by any government or subdivision or agency thereof, or any other applicable third-party payor;
- Services or supplies which are experimental, investigative, or for the purposes of research, including, but not limited to, services and supplies that have not been approved by the American Medical Association, the Food and Drug Administration, the appropriate medical specialty society, or the appropriate governmental agency, all phases of clinical trials, all treatment protocols based upon or similar to those used in clinical trials, or any treatment not generally accepted by the physician's profession in the United States as safe and effective for diagnosis and treatment;
- Services or supplies performed or provided while you are not covered by the Plan;
- Services or supplies for which you are not legally obligated to pay or for which no charge would be made in the absence of the Plan;
- Services for the evaluation or treatment of mental or psychological damage or harm, except to the extent provided above;
- Services or supplies for personal comfort or convenience, such as a private room, television, telephone, radio, guest trays, and similar items;
- Fraudulent claims or claims not filed in good faith as determined by the Claims Administrator;

- Canceled appointment charges;
- Self-administered services;
- Services or supplies to which your condition is persistently nonresponsive;
- Services or supplies relating to Preexisting Conditions, except to the limited extent (if any) that an Approved Physician clearly confirms an identifiable and significant aggravation (incurred in the Course and Scope of Employment) of a Preexisting Condition; provided, however, that --
 - coverage for such aggravation will be provided only if and to the extent that the Approved Physician -
 - confirms that the Preexisting Condition has been previously repaired or rehabilitated, and
 - prescribes services or supplies that are medically necessary to treat such aggravation and likely to return you to pre-Injury status; and
 - no coverage will be provided if the Preexisting Condition was a major contributing cause of the Injury;
- Acupuncture, behavior modification, pain management programs, hypnosis, biofeedback, other forms of self-care or self-help training or any related diagnostic testing, or any service or supply ancillary to any of these treatments;
- Chiropractic or spinal manipulation services;
- Substance abuse services;
- Services and supplies provided in or out of a rest home, convalescent facility, nursing home, or other institution that only assist with activities of daily living such as bathing, dressing, walking, eating, preparing special diets, or the supervision of taking medications, no matter by whom recommended or furnished;
- Charges for the purchase, rental or repair of bedding, or environmental control devices, including, but not limited to, an air conditioner, humidifier, dehumidifier, or air purifier, and charges for jacuzzis, saunas, vans, or structural changes to your residence or moving expenses;
- Charges for services performed by:
 - a person who normally lives with you;
 - your spouse;
 - a parent of you or your spouse;
 - a child of you or your spouse; or
 - a brother or sister of you or your spouse; and

- The cost of any other service or supply not specified above as a Covered Charge.

Treatment and Denial

Any provision of this Plan to the contrary notwithstanding, the Employer may render first aid, or the Plan may pay for Emergency Care, pay Wage Replacement Benefits or pay for a medical evaluation or treatment, and the Plan can still make a subsequent determination that you have not suffered a covered Injury or otherwise deny any or all further benefits under the provisions of this Plan.

Medical Provider Referrals

If the treating Approved Physician finds it necessary to refer you to another health care provider, the treating Approved Physician must notify you and the Claims Administrator of his or her desire to make the referral and the objectives of such referral. The Claims Administrator will provide advance approval or disapproval of all referrals (and may rescind any such approval at any time) based upon such criteria as the Claims Administrator may determine for the effective administration of the Plan. **It is your responsibility to determine the status of any such approval or disapproval, and the expense of services or supplies relating to any disapproved referral will be solely your responsibility.**

No Interference with Patient-Provider Relationship

Although benefits under this Plan are conditioned on your use of only Approved Physicians and Approved Facilities, you remain entitled to seek any medical care that you deem appropriate from any provider of your choice at your own expense. **However, any medical expenses for this medical care will not be payable under this Plan and your use of a non-approved physician or facility may result in a complete denial or termination of benefits under this Plan.** The Employer, Claims Administrator, Appeals Committee, and their agents and delegates, shall not have any responsibility for the actual medical or other health care services provided by any Approved Physician, Approved Facility or other designated health care service provider. Health care providers are not agents of the Plan, Employer, Claims Administrator, or Appeals Committee. The Plan, Employer, Claims Administrator, and Appeals Committee are not liable or responsible for the acts or omissions of any health care provider. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of the attending Approved Physician and other health care providers based on their independent judgment for the provision of health care.

Second Medical Opinions

The Plan reserves the right to require a second medical opinion from an Approved Physician selected by the Claims Administrator for purposes of obtaining an Independent Medical Evaluation (IME) or for any other reason relating to the payment of Medical Benefits, Wage Replacement Benefits, or any other benefits under this Plan. If you refuse to be examined by an Approved Physician selected by the Claims Administrator for the second opinion, all benefits under the Plan will be suspended.

The Claims Administrator will weigh the findings of the treating Approved Physician and the Approved Physician providing the second opinion and make a benefit determination under the Plan. However, if you disagree with the diagnosis or treatment recommended by the Approved Physician whose opinion is accepted by the Claims Administrator ("Physician A"), then you may request a second medical opinion. **You must notify your Claims Administrator in advance of receiving any second medical opinion in order for this opinion to be considered by the Plan.** If you provide advance notice to the Claims Administrator, then you shall have the right to a one-time examination at your own expense by another physician ("Physician B"). This examination by Physician B will be solely for the purpose of evaluating your condition and making a treatment recommendation.

If the diagnosis and treatment recommended by Physician B is contrary to that of Physician A, then the Claims Administrator shall designate a peer review physician who will evaluate the medical records and advise the Claims Administrator, and who may designate another Approved Physician for a further medical examination. **If you refuse to be so examined, all benefits under the Plan will be suspended.** The diagnosis and/or recommended treatment of the peer review physician or this last Approved Physician will be controlling. The fees and related expenses of the peer review physician and this last Approved Physician will be paid by the Plan (although you will have the option of paying up to one-half of such fees and expenses).

When Medical Benefits Cease

Medical Benefits will cease upon the earliest of:

- the expiration of 126 weeks from the date of the Injury;
- reaching the Maximum Benefit Limit;
- involuntary termination of your employment with the Employer for gross misconduct;
- the date that you do not receive medical treatment from an Approved Physician or Approved Facility (or scheduled treatment with an Approved Physician or Approved Facility has not been approved by the Claims Administrator) for a period of more than 60 days; or
- the date you reach Maximum Rehabilitative Capacity (as determined by an Approved Physician), or your failure to comply with the requirements specified under the CONTINUING BENEFITS section of this booklet.

REQUESTING BENEFITS

The following is a summary of the procedures for requesting benefits under this Plan. Also see the DETAILED CLAIM PROCEDURES in the next section of this booklet.

Notice of Injury

You (or your Representative) must provide verbal notice of an Injury **immediately** to your Supervisor, Safety Manager, Human Resources Manager, Risk Management Manager or Health Services.

- **For an Injury due to an Accident, or known exposure to an Occupational Disease, this verbal notice must be provided by the end of the workshift for the date of the Injury.**
- **For an actual Injury due to Occupational Disease or Cumulative Trauma, this verbal notice must be provided by the earlier of the following: (1) within 24 hours after being medically diagnosed with a work-related Injury, or (2) within 72 hours after you should have known of the work-related Injury.**

With respect to reporting an Injury due to Occupational Disease or Cumulative Trauma, if the Employer has purchased an insurance policy as described above, the purpose of which (in whole or in part) is to pay Plan benefits to a participant or reimburse the Employer for Plan benefits, then the notice of Injury from Occupational Disease or Cumulative Trauma must in all events be provided not later than 35 months after the end of the policy period.

You must also notify your Supervisor (verbally or in writing) of your expected recovery time (1) immediately after receiving your first medical treatment for an Injury, and (2) after each following appointment with your treating Approved Physician.

Providing Required Information

You (or your Representative) must complete the incident report form and medical authorization form **within 24 hours after the Injury is reported.** These forms must be submitted to your Supervisor (or such other person as the Claims Administrator may specify). You must provide verbal, written, or recorded statements, and provide such proof and demonstrations (relating to the Injury or any prior or subsequent damage or harm you suffered, in or out of the Course and Scope of Employment), in such manner and within such periods, as the Claims Administrator may direct from time-to-time.

An immediate incident report to your supervisor is essential so that the Claims Administrator can promptly verify the facts regarding your Injury and pay appropriate benefits. No benefits will be payable under the Plan if:

- notice of Injury is not provided as specified above, unless the Claims Administrator determines that good cause exists for failure to give notice in a timely manner; or
- all required information is not provided as specified above, unless the Claims Administrator determines that good cause exists for failure to provide such information in a timely manner.

Medical Examination

You must submit to medical examinations or evaluations as often as the Claims Administrator determines to be reasonably necessary or appropriate.

CONTINUING BENEFITS

Subject to the limitations and other rules and procedures described in this booklet, your benefits under this Plan will begin or continue as long as you --

- submit to any requested drug and/or alcohol testing in accordance with the applicable Employer's substance abuse policy, and provide the Employer with this alcohol and/or drug testing information or authorize the Employer to gain access to this information;
- receive prior approval for all medical care (except in the case of Emergency Care, as explained in the MEDICAL BENEFITS sections of this booklet);
- utilize only Approved Physicians and Approved Facilities (except in the case of Emergency Care, as explained in the MEDICAL BENEFITS sections of this booklet);
- submit to examination by an Approved Physician selected by the Claims Administrator (other than the treating Approved Physician) as required by the Claims Administrator with respect to any surgical procedure or other diagnosis or treatment opinion rendered by the treating Approved Physician for which the Claims Administrator considers a second medical opinion advisable;
- do not reach Maximum Rehabilitative Capacity or are otherwise responsive to treatment. Nonresponsiveness would include, but not be limited to, nonresponsiveness due to the need for participant behavioral modification recommended by the treating Approved Physician;
- provide accurate information to, and follow the directions of, a treating Approved Physician. Following the directions of a treating Approved Physician includes, but is not limited to, any recommended treatment, therapy, course of action, abstinence or rehabilitation program;
- allow an authorized representative of the Plan to go with you to appointments with health care providers;
- keep and be on time for all scheduled appointments with health care providers. Except in extraordinary circumstances as determined by the Claims Administrator, a first missed appointment will result in a warning and/or suspension of benefits and a second missed appointment will result in a termination of benefits;
- do not engage in conduct which hinders your recovery;

- actively participate in activities that increase the likelihood of your return to work or return to pre-injury status as directed by an Approved Physician, including but not limited to reporting work status or expected recovery time after each appointment;
- immediately inform your Supervisor, Safety Manager, Human Resources Manager, Risk Management Manager or Health Services that you have been released by an Approved Physician to return to full or Modified Duty, and timely report to work in accordance with such work release;
- do not receive benefits with respect to the Injury from any workers' compensation law (regardless of whether or not any coverage for benefits is actually in force under such law);
- are truthful and do not demonstrate bad faith in connection with administration of the Plan, including, but not limited to, any aspect of the required information supplied as part of the Injury reporting or employment process;
- fully cooperate with the Claims Administrator (including, but not limited to, the requirements on providing information) in connection with the administration of the Plan, including, but not limited to, subrogation or coordination of benefits procedures; and
- comply with the provisions of this summary plan description, the Plan, and the rules and procedures adopted by the Claims Administrator for the administration of the Plan.

DETAILED CLAIM PROCEDURES

Filing a Claim for Benefits

A claim for Medical Benefits, Wage Replacement Benefits, or Dismemberment Benefits under the Plan will be initiated by you (or your Representative) by complying with the injury notice and medical treatment requirements found in the REQUESTING BENEFITS section and other parts of this booklet. A claim for Death Benefits under the Plan shall be initiated by a Beneficiary providing notice of entitlement thereto to the Claims Administrator within 90 days after the date of the participant's death. If, within two years after any amount becomes payable under this Plan to an individual, but the individual fails to claim such amount and the Claims Administrator has exercised reasonable diligence in attempting to make such payment, the amount shall be forfeited and shall cease to be a liability of this Plan.

- **What is a Claim** -- Each (1) medical service or supply for which payment is requested, (2) Wage Replacement Benefit for a particular payroll period, or (3) claim for Death Benefits or Dismemberment Benefits, will be deemed a separate "claim" for benefits that is subject to a determination under the Plan. The Plan's payment of a particular claim (for example, payment for an initial medical evaluation, even on a claim that may have been reported late) does not waive or otherwise prejudice the

Claims Administrator's or Appeals Committee's right to deny another particular claim or all future claims for benefits under the Plan. Any failure by the Claims Administrator or Appeals Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Claims Administrator's or Appeals Committee's authority to apply such provisions thereafter.

- **Who is a Claimant** -- A claimant or a claimant's Representative may file a claim for benefits under the Plan, as well as an appeal of an Adverse Benefit Determination. References in this DETAILED CLAIMS PROCEDURES section to "claimant" may include you, a medical provider seeking payment for a service or supply, or a claimant's authorized Representative, as applicable.
- **Information to Submit** -- Claims must include the information required by the REQUESTING BENEFITS section above and such other reasonable information requested by the Claims Administrator, such as medical records or a written statement from an independent service provider evidencing the date, type of services rendered, and the total cost of such services. In addition, the Claims Administrator may require the claimant to provide a written and signed statement that provides that the amounts requested for payment under this Plan have not been reimbursed, or is not reimbursable under any other plan or program. Further, the Claims Administrator may also request that the claimant file all appropriate claims and requests for payment from any other plan or program maintained by the claimant prior to making any payments under this Plan. See the OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFITS section of this booklet.
- **Submission of Medical Bills for Payment** -- Approved Physicians and Approved Facilities will be requested to invoice all health care-related charges directly to the Claims Administrator (or the Employer, which will immediately transmit such invoice to the Claims Administrator). However, in the event that you receive such an invoice or pay such a charge, you must file all requests for payment or reimbursement of covered charges with the Claims Administrator within 30 days from the date such expenses are incurred or, if later, the date you receive an invoice from an Approved Physician, Approved Facility, or other health care provider (in the case of Emergency Care) for such expenses.
- **Incomplete Claim Submissions** -- If a claim, as originally submitted, is not complete, the Claims Administrator will notify the claimant in the manner described below, and the claimant will have the responsibility for providing the missing information. Subject to the applicable provisions of this DETAILED CLAIMS PROCEDURES, if the period of time for a particular claim is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination will be suspended from the date on which the notification of the extension is sent to the claimant until the date on which the Claims Administrator receives the claimant's response to the request for additional information.

Claims Review Procedures

- **Notice of Initial Benefit Determination** - The Claims Administrator will provide notice to the claimant of its initial benefit determination as follows:
 - **Urgent Care, Pre-Service Medical Claims** - In the case of an Urgent Care Claim for Medical Benefits, the Claims Administrator will notify the claimant of the Plan's initial benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies of the particular claim, but not later than 72 hours after receipt of the claim. However, if the claimant (1) fails to follow the Plan's procedures for filing an Urgent Care Claim, or (2) otherwise fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan on an Urgent Care Claim, then:
 - The Claims Administrator will notify the claimant as soon as possible, but not later than 24 hours after its receipt of the claim, of the procedure to follow or the specific information necessary to complete the claim. This notice requirement will only apply to the extent that such failure is a communication by a claimant that is received by the Claims Administrator, and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.
 - The claimant will then be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to correct such failure.
 - The Claims Administrator will then notify the claimant of the Plan's initial benefit determination as soon as possible, but not later than 48 hours after the earlier of (i) the Claims Administrator's receipt of the specified information necessary to complete the claim, or (ii) the end of the time period given the claimant to provide such information.
 - **Concurrent Medical Care Decisions** - If the Claims Administrator has approved an ongoing course of medical treatment to be provided over a period of time or number of treatments:
 - The Claims Administrator will notify the claimant of any reduction or termination by the Plan of such course of treatment. Such reduction or termination will be considered an Adverse Benefit Determination and the Claims Administrator will notify the claimant sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a benefit determination on review before the course of treatment is actually reduced or terminated.
 - Any request by a claimant to extend the course of treatment beyond the prescribed period of time or number of treatments previously approved by the Plan that is an Urgent Care Claim will be decided as soon as possible, taking into account the medical exigencies of the claim. The Claims Administrator

will make an initial benefit determination, whether adverse or not, within 24 hours after its receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If such claim is not made to the Plan within such 24-hour period, the request will be treated as an Urgent Care Claim and be decided within the normal Urgent Care Claim timeframes (in other words, as soon as possible, taking into account the medical exigencies of the claim, but not later than 72 hours after receipt).

- Any request by a claimant to extend the course of treatment beyond the prescribed period of time or number of treatments previously approved by the Plan that is not an Urgent Care Claim will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (i.e., as a Pre-Service Claim or a Post-Service Claim).

Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving an Urgent Care Claim or not, will be made in accordance with the provisions of this section of the booklet.

- **Non-Urgent Care, Pre-Service Medical Claims** - In the case of a Pre-Service Claim for Medical Benefits that is not an Urgent Care Claim, the Claims Administrator will notify the claimant of the Plan's initial benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after its receipt of the claim.
 - If the claimant fails to follow the Plan's procedures for filing a non-urgent care, Pre-Service Claim, then the Claims Administrator will notify the claimant as soon as possible, but not later than 5 days after its receipt of the claim, of the procedure to follow. This notice requirement will only apply to the extent that such failure is a communication by a claimant that is received by the Claims Administrator, and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.
 - The Claims Administrator may extend the 15-day benefit determination period up to an additional 15 days if it determines that, due to matters beyond the control of the Plan, an initial benefit determination cannot be made within the first 15-day period, and notifies the claimant of the special circumstances requiring the extension and the date by which the Plan expects to render a decision. If additional information is necessary to decide the claim, the extension notice shall specifically describe the required information and the claimant shall then be given at least 45 days to provide the specified information. However, the Claims Administrator's timeframe for making a benefit Determination shall be suspended until the date upon which the claimant responds to the request for additional information.

- **Post-Service Medical Benefit, Wage Replacement Benefit, Death Benefit, and Dismemberment Benefit Claims** - In the case of a Post-Service Claim for Medical Benefits or a claim for Wage Replacement Benefits, Death Benefits or Dismemberment Benefits, the Claims Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after its receipt of the claim. The Claims Administrator may extend this period up to an additional 15 days if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan. Notice of such extension must be provided to the claimant prior to the expiration of the initial 30-day period and state (1) the special circumstances requiring the extension, and (2) the date by which the Plan expects to render a decision. If the extension relates to a claim for Wage Replacement Benefits, such notice will also state (1) the standards on which entitlement to benefits is based, and (2) unresolved issues that prevent a benefit determination on the claim and what additional information is needed to resolve those issues. If additional information is requested with the extension notice, the claimant will have 45 days from the date of the notice of extension to provide the specified information. However, the Claims Administrator's timeframe for making a benefit determination shall be suspended until the date upon which the claimant responds to the request for additional information.
- **Manner and Content of Adverse Benefit Determinations** - If the initial benefit determination is an Adverse Benefit Determination, the Claims Administrator will provide a written or electronic notice to the claimant that satisfies the following requirements:
 - Any electronic notice will satisfy ERISA regulations that specify the standards for electronic disclosure of benefit plan information;
 - The notice will be written in a manner calculated to be understood by the claimant;
 - The notice will set forth the specific reason or reasons for the Adverse Benefit Determination, making reference to the specific Plan provisions on which the Adverse Benefit Determination is based;
 - If an internal rule, guideline, protocol or other similar criterion was relied upon in making an Adverse Benefit Determination on a claim for Medical Benefits or Wage Replacement Benefits, the notice will state that such rule, guideline, protocol or other similar criterion was relied upon and that a copy thereof will be provided free of charge to the claimant upon request;
 - If the Adverse Benefit Determination of a Medical Benefits or Wage Replacement Benefits claim is based upon medical necessity, an experimental treatment or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the Adverse Benefit Determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- The notice shall include a statement that in the case of an Adverse Benefit Determination on review by the Appeals Committee, the Plan offers no further voluntary levels of appeal and that the claimant can pursue his or her right to bring a legal action under ERISA section 502(a);
- If the initial Adverse Benefit Determination involves an Urgent Care Claim, the notice will provide a description of the expedited review process applicable to such claims. Notification of an Adverse Benefit Determination that involves an Urgent Care Claim may be provided to the claimant orally within the time frames specified above, provided that the oral notification satisfies the requirements of this subsection and that a written or electronic notice satisfying the requirements of this subsection is furnished to the claimant not later than 3 days after the oral notification;
- The notice will describe any additional materials or information necessary for the claimant to perfect the claim and explain why such material or information is necessary; and
- The notice will provide a description of the Plan's review procedures (including the time limits applicable to these review procedures).

➤ **Appeal of Adverse Benefit Determinations** -- The claimant may appeal in writing an Adverse Benefit Determination to the Appeals Committee within the following number of days following his or her receipt of the Adverse Benefit Determination from the Claims Administrator:

- 180 days for a Medical Benefits or Wage Replacement Benefits claim; or
- 60 days for a Death Benefit or Dismemberment Benefit claim.

If the Adverse Benefit Determination involves an Urgent Care Claim for Medical Benefits, the claimant may request orally or in writing an expedited review of the Adverse Benefit Determination and all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile or other available expeditious method.

➤ **Appeals Committee Consideration** -- When reviewing the appeal of an Adverse Benefit Determination, the Appeals Committee will comply with the following requirements:

- The claimant may submit written comments, documents, records, and other information relating to the claim for benefits, and the Appeals Committee will take all of such information into account when reviewing the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

- The claimant may receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information that is relevant to the claimant's claim for benefits (as determined by the Appeals Committee);
 - The Appeals Committee review of an Adverse Benefit Determination on a claim for Medical Benefits or Wage Replacement Benefits will not give any deference to the claimant's initial Adverse Benefit Determination.
 - If the appeal request on a Medical Benefits or Wage Replacement Benefits claim is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the Appeals Committee will consult with an Approved Physician who has appropriate training and experience in the field of medicine involved in the medical judgment. This Approved Physician will not be an individual who was consulted in connection with the initial Adverse Benefit Determination or a subordinate of such individual
 - Upon request of a claimant, the Appeals Committee will identify the individual names of any medical or vocational experts whose advice was obtained in connection with an initial Adverse Benefit Determination of a Medical Benefits or Wage Replacement Benefits claim, without regard to whether the advice of such experts was relied upon in making the benefit determination.
- **Timing of Notice of Benefit Determination on Review** - The Appeals Committee will provide notice to the claimant, as described below, of the Plan's benefit determination on review in accordance with the following timeframes:
- **Urgent Care, Pre-Service Medical Claims** - In the case of a Pre-Service Claim for Medical Benefits that is an Urgent Care Claim, the Appeals Committee will notify the claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies of the claim, but not later than 72 hours after its receipt of the claimant's appeal request. No extension of time is available for Appeals Committee determinations on the review of claims for Medical Benefits.
 - **Non-Urgent Care, Pre-Service Medical Claims** - In the case of a Pre-Service Claim for Medical Benefits that is not an Urgent Care Claim, the Appeals Committee will notify the claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after its receipt of the appeal request. No extension of time is available for Appeals Committee determinations on the review of claims for Medical Benefits.
 - **Post-Service Medical Benefit, Wage Replacement Benefit, Death Benefit, and Dismemberment Benefit Claims** - In the case of a Post-Service Claim for Medical Benefits or a claim for Wage Replacement Benefits, Death Benefits or Dismemberment Benefits, the Appeals Committee will notify the claimant of the

Plan's benefit determination on review within 45 days after its receipt of the appeal request. The Appeals Committee may extend this period up to an additional 45 days on a claim for Wage Replacement Benefits, Death Benefits, or Dismemberment Benefits if the Appeals Committee determines that an extension is necessary due to matters beyond the control of the Plan. Written or electronic notification of an extension must be provided to the claimant prior to the expiration of the initial 45-day period and indicate the special circumstances requiring the extension and the date by which the Plan expects to render a decision.

- **Manner and Content of Benefit Determination on Review** - The Appeals Committee will provide a claimant with written or electronic notification of the Plan's benefit determination on review. If the decision on review is an Adverse Benefit Determination, the notice must satisfy all the requirements set forth in the first six bullets under the "Manner and Content of Adverse Benefit Determination" section above, and also state that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for Plan benefits.
- **Extension of Time Frames Allowed by Law or Agreement** - In the event that ERISA rules and regulations permit additional time for decisions or actions by the Claims Administrator or Appeals Committee, the Claims Administrator or Appeals Committee may exercise their discretion to utilize (but not exceed) those extended time frames; provided, however, that this discretion will only be exercised when necessary to provide a full and fair review of a claimant's right to benefits in accordance with the terms of this Plan (for example, additional time is needed to obtain an appointment and results of a medical examination). Upon request by the Plan, a claimant may also voluntarily agree to an extension or further extension of any time period within which the Plan must decide a claim.
- **Exhaustion of Administrative Remedies:** No legal action can be brought by or with respect to you to recover benefits under the Plan before the foregoing claim procedures have been exhausted. Every ERISA right of action by you, your Representative, Beneficiary or estate against the Plan, or any Plan fiduciary, must be brought no later than one (1) year from the date that the foregoing claim procedures have been exhausted (due to claimant inaction, claimant receipt of a final Adverse Benefit Determination on appeal, or otherwise). Unless contrary to applicable law, any ERISA right of action or other legal action challenging a Plan decision shall be brought in the United States District Court for the Northern District of Texas, Dallas Division.

FINAL COMPROMISE AND SETTLEMENT

At the Claims Administrator's option within 126 weeks after the date of Injury, and at any time if the Claims Administrator elects to extend such 126-week period after the date of Injury, the Claims Administrator may notify you of the Plan's intention to be released from any further known and unknown benefit and all other injury-related claims by you

and pay a final claim settlement to, or with respect to, you in exchange for your agreement to a release of liability in favor of the Plan, Employer, Claims Administrator, Appeals Committee and other interested parties with respect to such claims. In that event, the Claims Administrator may appoint an actuary, appraiser, and/or Approved Physician to investigate, determine, and capitalize such claims, or use such other valuation method as the Claims Administrator may specify. The payment by the Plan and/or Employer of the value of such claims (as finally determined by the Claims Administrator) will be made in such manner as the Claims Administrator may determine. No additional claims will be subsequently accepted with respect to such Injury. Any actuary or appraiser will apply such rules, standards, and assumptions (present value discount, inflation, and mortality rates, etc.) as the Claims Administrator may determine. You must cooperate and provide all information, sign such forms and agreements, and submit to all medical examinations as may be requested by the Claims Administrator to arrive at a valuation and settlement of your claims. No further benefits will be payable to, or with respect to, you if you fail or refuse to accept the Claims Administrator's claim valuation, sign the release agreement presented by the Claims Administrator, or otherwise comply with the requirements of this section or other provisions of the Plan. Prior or subsequent to the Claims Administrator's evaluation and determination of the value of your claims, the Claims Administrator may determine to not capitalize and satisfy any such claim as described above and to instead continue eligibility for benefit payments and defer the above valuation and settlement.

OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFIT

Offset For Other Benefits

Benefit payments under this Plan shall be reduced by:

- the amount of any applicable federal or state income, employment, or other taxes that are required by law to be withheld;
- your earnings from any employer after disability begins, amounts legally garnished, and your contributions (through salary reduction or otherwise) to a 401(k) or a 403(b) plan, cafeteria plan, or other pre-tax salary deferral employee benefit plan; and
- except as otherwise specified in the Plan's "Coordination of Benefits" section, any amount paid or available with respect to your Injury under the following: Social Security Act, the Railroad Retirement Act, workers' compensation law, unemployment compensation law, occupational disease law or any other government program or similar law. The Plan shall deduct from Plan benefits the estimated benefit amounts for which you are likely to be eligible under such other deductible sources of income, regardless of whether you actually apply for such other deductible source of income.

Coordination Of Benefits

If you are covered under this Plan and one or more other benefit plans, then (unless otherwise subject to the “Subrogation and Reimbursement Rights” section) any Medical Benefits and Wage Replacement Benefits payable under this Plan will be either regular benefits or reduced benefits that, when added to the benefits of the other plan(s), will not exceed 100% of the amount described herein. The purpose of this provision is to prevent duplicate payments under plans that would exceed 100% of the benefits described in this Plan. In the coordination of benefits, one of the plans will be designated as the primary plan and the other plans will be designated as secondary. The primary plan will pay its full benefits first, then the secondary plan(s) will pay, but payments will be coordinated so that the total from all plans will not be more than the benefits described in this Plan.

- For purposes of this section, “other benefit plans” shall mean any health or disability-type benefits provided under (1) any individual, group, blanket or franchise plan, (2) other prepaid coverage under service plan contracts, or under group or individual plans, policies or a practice, (3) uninsured arrangements of group or group-type coverage, (4) labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans, (5) benefits coverage in a group, group-type and individual policy or policies of automobile coverage (including, but not limited to medical payment coverage, personal injury protection coverage, uninsured motorists coverage and underinsured motorists coverage, and (6) any other group-type contracts – that is, those contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.
- Except as specified below, if a person is covered by more than one plan to which this coordination of benefits provision applies, then the following rules will determine which plan will be primary:
 - With respect to health benefits only, when only one of the plans has a coordination of benefits provision, then the plan without such a provision will be the primary plan;
 - The plan under which the person is covered other than as a dependent (for example, active associate, former associate, inactive associate, COBRA participant or retiree) will be the primary plan over a plan which covers the person as a dependent;
 - The plan under which the person is covered as an active associate will be the primary plan over a plan which covers the person as former associate, inactive associate, COBRA participant or retiree;
 - If none of these rules establish an order of benefit determination, then the plan that has covered the person for the longer period of time will be the primary plan.

- Any provision herein to the contrary notwithstanding, Medical Benefits payable under this Plan to or with respect to any person who is in "current employment status" as defined for purposes of Medicare, and who is eligible for benefits under Medicare, shall be primary and shall not be reduced by the amount of benefits payable to or with respect to such person under Medicare, which will be considered the secondary plan. However, Medical Benefits payable under this Plan to or with respect to any person who is not in "current employment status," as defined for purposes of Medicare, and who is eligible for benefits under Medicare, shall be secondary and reduced by the amount of all benefits payable to or with respect to such person under Medicare, which will be the primary plan. In addition, the fact that a person is eligible for or provided medical assistance under a state plan will not be taken into account in making payments under the Plan.
- You must notify the Claims Administrator of such other benefit plans and cooperate with the Claims Administrator in (1) furnishing copies of other policies, coverages or plans which may be applicable to the Injury, and in (2) completing and returning to such Claims Administrator any questionnaire or forms inquiring about, or assigning rights to recover under, other policies, coverages or plans which may cover or be applicable to you.

Subrogation and Reimbursement Rights

For purposes of "Subrogation and Reimbursement Rights", the "Notice of Legal Proceedings," and "Assignment of Rights" sections of this Plan, the term "Payee" means you or your Beneficiary or your respective family members, heirs, estate, or other Representative (in their individual or representative capacity), singularly or collectively as the context may require to give the Plan the broadest possible rights of recovery.

- **Right of Subrogation** - If a Payee becomes entitled to or directly or indirectly receives Plan benefits for any Injury caused by the negligence or other act or omission of any person or organization (including, but not limited to, the Employer), and is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury (including, but not limited to, damages for negligence, survival, wrongful death or other legal or equitable action), whether by insurance, litigation, settlement or other proceeding, the Payee shall automatically be required to (i) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation to the extent of the Plan benefits paid to, or with respect to, the Payee and (ii) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation for all medical management, investigation, attorneys' fees, costs of recovery, and other expenses related to the claim for benefits (including any subrogation proceeding). The subrogation rights of this Plan even apply with respect to a Payee who is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury but has not and will not receive any Plan benefits if such person's claim for damages or other compensation is dependent on whether the participant had or has a valid claim against a third party.

- **Written Confirmation** - Upon request of the Plan, the Payee shall provide the Plan written confirmation of this subrogation right, including execution of any assignment, lien form or other document requested by the Claims Administrator to enable the Plan to recover such Plan benefits and related expenses. Any failure of a Payee to give written confirmation of the Plan's subrogation rights does not adversely affect its rights of subrogation because the Plan's right of subrogation arises automatically once payment under this Plan is made to or on behalf of the Payee.
- **Right to Reimbursement** - If (i) a Payee fails, refuses or neglects to reimburse the Plan or otherwise comply with the provisions of this section, or (ii) payments are made under the Plan based on fraudulent information or otherwise in excess of the amount necessary to satisfy the provisions of the Plan, then the Plan shall still have all remedies and rights of recovery specified herein. The Plan shall also have the right to terminate or suspend benefit payments and/or recover the reimbursement of all amounts above due to the Plan by withholding, offsetting and recovering such amounts out of any future Plan benefits or amounts otherwise due from the Plan to or with respect to such Payee.
- **Right of Recovery** - The Plan shall have the first lien recovery against any benefits paid or to be paid by the Plan. The Plan shall also have the right to bring a lawsuit and assert a constructive trust or other interest against any and all persons that have assets to which the Plan can claim rights. The Plan has the right of first recovery from any judgment, settlement or other payment, regardless of whether the Payee has been "made whole."
- **Attorney's Fees and Expenses** - The Plan's subrogation rights and first lien will not be reduced by attorneys' fees or expenses incurred by any party in pursuing recovery against a third party and the "common fund" doctrine shall not apply. Any attorneys' fees and/or expenses incurred by or at the request of the Payee or his, her or its attorneys in a third party or other action shall be the sole responsibility of such party.

Notice of Legal Proceedings

A Payee (whether or not such person has received or may in the future directly or indirectly receive Plan benefits) shall provide the Claims Administrator with prior written notice of the involvement of such party in any lawsuit, settlement discussion or other proceeding (for negligence, wrongful death, survival or other cause of action), one of the principal purposes of which is recovering, from any person or organization, damages or other compensation in any way related to any Injury for which Plan benefits have been or may in the future be paid. The Plan shall have the right to intervene for itself and on behalf of a Payee in any such lawsuit, settlement discussion or other proceeding. If a Payee neglects, fails or refuses to seek a recovery from any person or organization for any Injury caused by the negligence or other act or omission of such person or organization, the Plan shall have the right to institute a lawsuit or other proceeding or do any other act that in the opinion of the Claims Administrator may be necessary or desirable to recover the Plan benefits paid (and to be paid in the future), plus all medical

management, investigation, attorneys' fees, costs of recovery, and other expenses incurred by the Plan.

Assignment of Rights

By participating in this Plan, a participant obligates himself or herself, as well as all other Payees (in both their individual and representative capacities), to the provisions of this Plan, including, without limitation, the "Subrogation and Reimbursement Rights," "Notice of Legal Proceedings," and "Assignment of Rights" sections hereof. Upon the request of the Claims Administrator, a Payee shall assign to the Plan the right to intervene in or institute any lawsuit, settlement discussion, or other proceeding described in the "Subrogation and Reimbursement Rights," and "Notice of Legal Proceedings," sections, and to use the name of such party for such purpose. The Plan shall have the right to select legal counsel of its own choice and such counsel shall have complete control over the conduct of any such lawsuit, settlement discussion, or other proceeding without the consent or participation of any such Payee. Whenever the Plan shall intervene in or institute any lawsuit or other proceeding as permitted by the provisions of this section, the Plan may pursue same to a final determination and the Plan expressly reserves the right to appeal from any adverse judgment or decision. The Payee shall give the Plan all reasonable aid in any such lawsuit, settlement discussion, or other proceeding in effecting settlement, in securing evidence, in obtaining witnesses, or as may otherwise be requested by the Claims Administrator. The Payee shall release the Plan, the Employer, the Plan Administrator, the Claims Administrator, the Appeals Committee, and their respective directors, officers, agents, consultants, attorneys, and associates from all claims, causes of action, damages and liabilities of whatever kind or character that may directly or indirectly arise out of the pursuit or handling by the Plan of any such lawsuit, settlement discussion or other proceeding.

Right To Receive And Release Necessary Information

The Claims Administrator may, without the consent of or notice to any person or organization, release to or obtain from any person or organization, information needed to implement Plan provisions. When you request benefits, you must furnish all information requested by the Claims Administrator.

APPLICABLE LAW

This Plan shall be governed and construed in accordance with the provisions of ERISA and, except where superseded by federal law, the laws of the State of Texas. This Plan is exempt from the group health plan requirements of:

- Part 7 of ERISA by operation of one or a combination of the excepted benefits listed in ERISA Section 733(c)(1) and is therefore exempt from the standards, rules, regulations and other requirements of the Health Insurance Portability and Accountability Act ("HIPAA"),

- The Public Health Service Act by operation of one or a combination of the excepted benefits listed in Title 42 of the United States Code Section 300gg-91(c)(1) and is therefore exempt from the standards, rules, regulations and other requirements of the Patient Protection and Affordable Care Act (“PPACA”).
- Any other standards, rules, regulations or other requirements that utilize or reference the excepted benefits definition listed in ERISA Section 733(c)(1).

AMENDMENT OR TERMINATION OF PLAN

The Company presently intends to continue the Plan indefinitely, but the Company reserves the right to amend, modify, or terminate the Plan at any time; provided, however, that no such amendment or termination will reduce the amount of any benefit payable to, or with respect to, you under the Plan in connection with an Injury occurring prior to the date of such amendment or termination. Any such amendment or termination will be adopted pursuant to formal written action of a representative authorized to act on behalf of the Company.

DEFINITIONS

This section defines specific terms used in this booklet. These definitions should not be interpreted to extend coverage unless specifically provided for in the other sections of this booklet and the Plan document.

ABBR

Annual Benefit Base Rate

Adverse Benefit Determination

A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit. For example, this includes denial, reduction or termination of benefits based upon (1) your ineligibility to participate in the Plan, (2) application of any utilization review, (3) a medical service being considered experimental, investigational or not medical necessary, or (4) you no longer being Disabled.

Appeals Committee

The designated decision maker appointed by the Plan Administrator to make determinations on appeal of benefit claims and otherwise administer the Plan on behalf of the Plan Administrator and all other Employers. The Appeals Committee’s fiduciary responsibility is limited to discretionary authority and ultimate decision-making authority with respect to any final appeals of denied claims. The Appeals Committee shall otherwise hold no further authority, responsibility or liability as related to the administration of the Plan.

The Appeals Committee shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which related to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise relative to a covered associate's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Appeals Committee as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested. Benefits under this Plan will be paid only if the Plan Administrator or the Appeals Committee decides, in its discretion, that the covered associate is entitled to them.

The Appeals Committee shall have the following duties with respect to the final appeals of denied claims: (1) To administer the Plan in accordance with its terms; (2) to determine all questions of eligibility, status and coverage under the Plan; (3) to interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms; (4) to make factual findings; (5) to decide disputes which may arise relative to a covered associate's rights; (6) to review referred appeals and to uphold or reverse any denials; and (7) to keep and maintain records pertaining to the referred appeals.

Approved Facility

A hospital, other medical care facility or other medical service or supply provider either expressly approved by the Claims Administrator, included on an approved list of facilities adopted by the Claims Administrator or otherwise approved in writing by the Claims Administrator upon the request of a Plan participant.

Approved Physician

A person duly licensed under applicable state law as a Medical Doctor or Doctor of Osteopathy and either expressly approved by the Claims Administrator, included in an approved list of physicians adopted by the Claims Administrator, or otherwise approved in writing by the Claims Administrator upon the request of a Plan participant.

Beneficiary

The person or persons determined in the following priority:

- If there is an Eligible Spouse or Domestic Partner, all Death Benefits shall be paid to the Eligible Spouse or Domestic Partner.
- If there is no Eligible Spouse or Domestic Partner, Death Benefits shall be paid in equal shares to the Eligible Children.
- If the participant is not survived by an Eligible Spouse or Domestic Partner or Eligible Child, any Death Benefits shall be paid to a surviving dependent (as determined in accordance with the support criteria set forth in section 152 of the

Internal Revenue Code and such other rules as the Claims Administrator may prescribe) of the participant who is a parent, sibling, or grandparent of the deceased participant. If more than one of those dependents survives the participant, any Death Benefits shall be divided among them in equal shares.

- If the participant is not survived by an Eligible Spouse, Domestic Partner, Eligible Child, or dependent who is a parent, sibling, or grandparent, no Death Benefits shall be payable.
- For purposes of this Section:
 - "Eligible Spouse" means the surviving Spouse, or Same-Sex Spouse of the deceased participant;
 - "Spouse" means a person of the opposite gender from the participant who is legally married to the participant as recognized by a marriage certificate issued under the laws of the State of Texas or similar government authority, or by a court decree of common law marriage (obtained at such person's sole initiative and expense).
 - "Same-Sex Spouse" means a person of the same gender as the participant whose marriage was performed in a jurisdiction that recognizes same sex marriage.
 - "Domestic Partner" means the surviving Domestic Partner of the deceased participant in which the partnership is a same-sex relationship where:
 - Each partner is age 18 or older;
 - The partners are financially interdependent;
 - Each partner is legally competent to enter into contracts;
 - The partners maintain a committed relationship;
 - The partners have lived together for at least twelve months prior to the date of the participant's death;
 - Neither partner is married is legally separated, or has another domestic partner on the date of the participant's death; and
 - The partners are not blood relatives to a degree closer than allowed for marriage in the State of Texas.
 - "Eligible Child" means a surviving child of the deceased participant, whether by blood, marriage, or legal adoption, and for which the parent-child relationship has been legally established prior to the date of the participant's death by evidence of birth certificate, adoption decree, or other court decree of paternity or maternity, if the child is:
 - under 18 years of age;
 - enrolled as a full-time student in an accredited educational institution and is less than 26 years of age; or

- because of a physical or mental handicap, a dependent (as determined in accordance with the support criteria set forth in section 152 of the Internal Revenue Code and such other rules as the Claims Administrator may prescribe) of the deceased Participant at the time of the participant's death.

Claims Administrator

The individual, individuals or entity appointed by the Company to make initial determinations of benefit claims under this Plan on behalf of the Employer.

Course and Scope of Employment

An activity of any kind or character for which you were hired and that has to do with, and originates in, the work, business, trade or profession of the Employer, and that is performed by you in the furtherance of the affairs or business of the Employer. The term includes activities conducted on the premises of the Employer or at other locations designated by the Employer. This term does not include:

- transportation to and from your place of employment, unless:
 - the transportation is furnished as part of your employment arrangement or is paid for by the Employer; provided, however, that this exception does not include commuting to or from your usual place of employment;
 - the means of the transportation are under the control of the Employer; or
 - you are directed in your employment to proceed from one place to another place. Commuting to the place where you begin Employer business and commuting away from the place where you cease Employer business will not be covered if such transportation is not paid for by the Employer or otherwise under Employer control.
- travel by you in furtherance of the affairs or business of the Employer if such travel is also in furtherance of personal or private affairs by you, unless:
 - the travel to the place where the Injury occurred would have been made even had there been no personal or private affairs by you to be furthered by the travel; and
 - the travel would not have been made had there been no affairs or business of the Employer to be furthered by the travel.
- any injury occurring before you clock in or otherwise begin work for the Employer, or after you clock out or otherwise cease work for the Employer.
- any injury occurring while you are on a work break, unless the injury occurs while you are on a permitted work break (for purposes other than eating or smoking).

Disabled or Disability

A Total Disability or a Partial Disability:

- A “Total Disability” means a medically demonstrable anatomical or physiological abnormality caused by an Injury, and commencing within six months from the date of Injury, which causes you to be -
 - unable to perform the normal duties for which you were employed;
 - under the regular care of an Approved Physician; and
 - unable to engage in Modified Duty or any other occupation for wage or profit.
- A “Partial Disability” means a medically demonstrable anatomical or physiological abnormality caused by an Injury that results in you being –
 - unable to fully perform the normal duties for which you were employed;
 - under the regular care of an Approved Physician;
 - released to Modified Duty by such Approved Physician; and
 - working for the Employer in a Modified Duty position approved by the Employer.

Emergency Care

A service or supply provided with respect to a medical condition manifesting itself by a sudden and unexpected onset of acute symptoms of sufficient severity that in the absence of immediate medical attention could reasonably be expected to (1) result in death, disfigurement, or permanent disability, or (2) result in substantial impairment of any bodily organ, part, or function.

Maximum Benefit Limit

The maximum amount of all benefits payable to you under the Plan with respect to an Injury. Payments made for each form of benefit will be counted towards the Maximum Benefit Limit amount. The Maximum Benefit Limit for this Plan is \$500,000; provided, however, that the aggregate amount of the Maximum Benefit Limits with respect to claims of all participants arising out of a single Accident, or related series of Accidents, or Occupational Disease or Cumulative Trauma exposure, will not exceed \$1,000,000. This aggregate amount may proportionally reduce the Maximum Benefit Limit applicable to each participant involved in such Accident, related series of Accidents, or exposure, in such manner as the Claims Administrator or Appeals Committee may determine.

Maximum Rehabilitative Capacity

The earliest date after which, based upon reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated.

Modified Duty

A temporary accommodation that allows you to perform your regular job, or an alternate, temporary job that complies with your work restrictions and the Employer's needs.

Plan

Sysco Injury Protection Plan

Plan Administrator

The Company is the plan administrator of the Plan for purposes of ERISA. The Plan is administered on behalf of the Company by the Claims Administrator and Appeals Committee.

Subject to the Plan claim procedures, both the Claims Administrator and the Appeals Committee have discretionary authority to interpret and implement the provisions of the Plan. Any failure by the Claims Administrator or Appeals Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Claims Administrator's or Appeals Committee's authority to apply such provisions thereafter. Every interpretation, choice, determination, or other exercise of authority by the Claims Administrator or Appeals Committee will be binding upon all affected parties, without restriction, however, on the right of the Claims Administrator or Appeals Committee to reconsider and redetermine such action. There shall be no de novo review by any arbitrator or court of any decision rendered by the Appeals Committee and any review of such decision shall be limited to determining whether the decision was so arbitrary and capricious as to be an abuse of discretion. The Claims Administrator or Appeals Committee may adopt any rules and procedures it considers necessary or appropriate for the administration of the Plan. The Claims Administrator or Appeals Committee may deny a claim for or suspend the payment of Plan benefits otherwise payable to you if you do not comply with any provision of the Plan or the rules and procedures adopted by the Claims Administrator or Appeals Committee. **Notwithstanding the foregoing, the Appeals Committee shall have final authority regarding any decision made with respect to the administration of the Plan.**

Post-Service Claim

Any claim for a Medical Benefit that is not a Pre-Service Claim.

Preexisting Condition

Your illness, injury, disease, impairment or other physical or mental condition, whether or not work-related, which originated or existed prior to the date of the Injury.

Pre-Injury Pay

For salaried and hourly participants, compensation from the Employer for the 52 consecutive weeks preceding the date of the Injury;

"Pre-Injury Pay" **will not include** medical opt-out credit, disqualifying dispositions, nonqualified stock options, miscellaneous non-401(k) eligible earnings, expense/allowances, meals/lodging reimbursements, severance pay, or any other form of compensation not recognized in the calculation of a participant's ABBR for benefit purposes.

Pre-Service Claim

Any claim for Medical Benefits with respect to which this Plan requires Claims Administrator approval in advance of obtaining medical care.

Representative

A person that a participant authorizes in writing to act on his/her behalf. The Plan will also recognize a legally valid power of attorney or a court or administrative agency order giving a person authority to take an act on a participant's behalf. In the case of an Urgent Care Claim, a physician with knowledge of the participant's condition may act as the participant's Representative.

Receipt, Safety Pledge and Dispute Resolution Acknowledgement

The form attached to the back of this SPD booklet.

Urgent Care Claim

Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent Pre-Service Claim determinations (generally, 15 days after the Claims Administrator's receipt of the claim):

- could seriously jeopardize your life or health or your ability to regain maximum function; or
- in the opinion of a physician with knowledge of the claimant's medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim is an Urgent Care Claim as described above shall be made by the Claims Administrator applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the claimant's medical condition determines that a claim is an Urgent Care Claim and clearly communicates such determination to the Claims Administrator, the Plan shall treat the claim as an Urgent Care Claim for purposes of this Plan.

The characterization of a claim as an Urgent Care Claim solely impacts the timeframes and other procedures for processing benefit claims and in no way changes this Plan's approved medical provider requirements, pre-authorization requirements, or other medical management requirements. These requirements generally provide that (1) except in the case of Emergency Care, no amount shall be considered a Covered Charge under the Plan unless treatment is pre-approved by the Claims Administrator and furnished by or under the direction of an Approved Physician or Approved Facility, and (2) all determinations relating to your physical condition (upon which the payment of benefits is based) must be made by an Approved Physician. Urgent Care Claims may not arise to the level of involving Emergency Care. Your decision to seek treatment from an urgent care clinic or hospital emergency room does not necessarily result in an Urgent Care Claim or involve Emergency Care. See the MEDICAL BENEFITS and DETAILED CLAIM PROCEDURES sections of this booklet for more information.

GENERAL INFORMATION

Type Of Plan and Administration

The Plan is a welfare benefit plan providing wage replacement, death, dismemberment and medical benefits (including certain dental and vision benefits) due to an Injury. The Plan is administered by the Claims Administrator and Appeals Committee to the extent such duties have been delegated to the Claims Administrator and Appeals Committee by the Plan Administrator.

Name And Address Of Primary Plan Sponsor

Sysco Corporation
1390 Enclave Parkway
Houston, Texas 77077

A list of the employers not participating in this Plan is attached to the back of this booklet as Appendix B.

Name and Address Of Plan Administrator

Any questions you may have about the Plan may be posed to the Plan Administrator by mail, c/o Risk Management Department, Sysco Corporation, 1390 Enclave Parkway, Houston, Texas 77077, or by telephone at (281) 584-1390.

Name And Address Of Person Designated As Agent For Service Of Legal Process

Capitol Corporate Services, Inc.
P.O. Box 1831
Austin, Texas 78767-9923

Service of legal process may also be made upon the Plan Administrator.

Employer And Plan Identification Numbers

The employer identification number assigned by the Internal Revenue Service to Sysco Corporation is 74-1648137. The plan number of the Plan is 502.

Plan Year

The Plan operates and keeps its records on the basis of the 12-month period ending each June 30.

ERISA RIGHTS STATEMENT

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as work sites) all documents governing the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to

\$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have brought a claim against to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

March 1, 2014

APPENDIX A

RESOLUTION OF CERTAIN INJURY-RELATED DISPUTES

DISPUTE RESOLUTION POLICY OVERVIEW

The Employer hereby adopts a mandatory company policy requiring that certain claims or disputes must be submitted to final and binding arbitration under this dispute resolution requirement ("Policy"). **This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute.**

(a) Definitions:

- (1) **"Associate"** means any person who is employed in the regular business of, and receives his or her pay by means of a salary, wage or commission directly from, an Employer and for whom an Employer files a Form W-2 with the Internal Revenue Service. This term does not include an independent contractor or third-party agent.
- (2) **"Company"** means Sysco Corporation, a Delaware corporation, whose principal place of business is located in Houston, Texas, or any successor thereto.
- (3) **"Employer"** means the Company and any incorporated or unincorporated trade or business that (1) is a member of a control group (with the meaning of Section 3(40) of ERISA) with respect to which the Company is also a member, and (2) maintains Associates whose employment with the Employer is principally located within the State of Texas.

(b) Covered Claims:

- (1) any legal or equitable claim or dispute relating to enforcement or interpretation of the dispute resolution provisions in a Receipt, Safety Pledge and Dispute Resolution Acknowledgement form, an Associate training program, or this Policy; and
- (2) any legal or equitable claim by or with respect to an Associate for any form of physical or psychological damage, harm or death which relates to an accident, occupational disease, or cumulative trauma (including, but not limited to, claims of negligence or gross negligence or discrimination; claims for intentional acts, assault, battery, negligent hiring/ training/ supervision/ retention, emotional distress, retaliatory discharge, or violation of any other noncriminal federal, state or other governmental common law, statute, regulation or ordinance in connection with a job-related injury, regardless of whether the common law doctrine was recognized or whether the statute, regulation or ordinance was enacted before or after the effective date of this Policy).
- (3) The determination of whether a claim is covered by this Policy.

This dispute resolution requirement includes all claims listed above that an Associate has now or in the future against an Employer, its officers, directors,

owners, Associates, representatives, agents, subsidiaries, affiliates, successors, or assigns (even if such claim relates to matters occurring before the effective date of this Policy, if the Associate has not filed a legal action in any court or with any governmental agency prior to such date).

- (c) **Excluded Claims:** This dispute resolution requirement does not, however, include the following claims:
- (1) **any legal or equitable claim under ERISA for benefits, fiduciary breach, or other problem or relief solely relating to benefits payable under this Plan.** If an Associate wishes to appeal a denial of benefits under the Plan, such Associate must follow the process described in ARTICLE VI of the Plan. After exhausting the appeal process outlined in ARTICLE VI of the Plan, any action challenging a Plan decision, or any other ERISA right of action, must be brought in the United States District Court for the Northern District of Texas, Dallas Division.
 - (2) Any claim filed with an administrative agency in accordance with applicable law.
 - (3) Any criminal act or complaint, including but not limited to, restitution by an Associate for a criminal act for which he or she has been found guilty or no contest, or if the criminal proceedings have been resolved by deferred adjudication.
- (d) **Covered Parties:** Neither an Associate nor an Employer shall be entitled to a bench or jury trial on any claim covered by this Policy. This Policy applies to all Associates without regard to whether they have completed and signed a Receipt, Safety Pledge and Dispute Resolution Acknowledgement form or similar written receipt. These provisions also apply to any claims that may be brought by an Associate's spouse, children, parents, beneficiaries, Representatives, executors, administrators, guardians, heirs or assigns (including, but not limited to, any survival or wrongful-death claims).
- (e) **Effective Date:** For Texas Associates that were hired by the Employer before March 1, 2014, any changes included in this updated Policy shall be effective on the later of (1) March 1, 2014, or (2) the fifteenth (15th) calendar day following the date that the Employer provided notice of this updated Policy to such Texas Associates. For Texas Associates that are hired by the Employer on or after March 1, 2014, any changes included in this updated Policy shall be effective March 1, 2014.

DISPUTE RESOLUTION PROCESS

- (a) **Required Notice of All Claims:** When a party seeks arbitration, such party must give written notice of any claim to the other party within the applicable statute of limitations. The day the act complained of occurred will be counted for purposes of determining the applicable period. If such notice is not given timely and in the manner described above, the claim shall be void and deemed waived. **The filing of a lawsuit will not toll the running of the applicable statute of limitations to request arbitration of a claim, nor will the doctrine of equitable tolling apply to extend the limitations period for the party to request arbitration.**

- (1) The party requesting arbitration must contact the Risk Management Department at the operating company to advise of the intent to seek arbitration and obtain the proper Notice of Arbitration forms for forwarding to the independent arbitration firm approved by the Company. The Notice of Arbitration forms must be sent in triplicate to the independent arbitration firm at the address set forth on the form. The Associate must also send written notice to the Employer, in care of the Legal Department, Sysco Corporation, 1390 Enclave Parkway, Houston, Texas 77077 (or such other person or address as the Employer may specify). If the Employer wishes to invoke arbitration, the Employer must also give written notice to the Associate at the last address recorded in the Associate's personnel file.
 - (2) The party requesting arbitration must specifically identify and describe in the written notice all claims asserted and the facts on which the claims are based. This written notice shall be sent certified or registered mail, return receipt requested. The responding party shall have the ability to file special exceptions with the arbitrator on the basis that the written notice does not satisfy the requirements of this Policy.
 - (3) If after expiration of the applicable statute of limitation (i) a court has ordered the parties to arbitrate, and (ii) such court or arbitrator for whatever reason has determined that the claim is not void and deemed waived, then the party that is compelled to arbitrate must initiate a claim for arbitration regarding such claim with the Risk Management Department at the operating company and serve the other party with 30 days of such order or the party's claim shall be void and deemed waived. Such notice must be given in the manner described above.
- (b) Arbitration Filing Fees:** A filing fee is required and must be paid at the time the Associate submits a request for arbitration. The Associate share of this cost shall equal to the standard Associate filing fee specified under the selected arbitration firm's then-current procedures. The Employer shall pay a nonrefundable arbitration filing fee equal to the standard employer filing fee specified under the selected arbitration firm's then-current procedures. The Employer will also pay the arbitrator's entire fee and any other administrative expenses; provided, however, that an Associate may elect to also pay up to one-half of these fees and expenses.
- (1) If the arbitrator finds completely in favor of the Associate on all claims, the Employer will reimburse the Associate for his or her share of the filing fee.
 - (2) If the Employer initiates the arbitration (by means other than a motion in court to compel arbitration), the Associate will pay no portion of the selected arbitration firm filing fees.
- (c) Choosing an Arbitrator:** Unless otherwise agreed to in writing by the parties, the arbitrator selected by the parties in accordance with those rules (1) shall be an attorney licensed to practice in the State of Texas with experience in personal injury litigation, and (2) shall be selected from a panel of arbitrators located in Dallas County, Texas. If the arbitrator so selected becomes unable to serve for any reason, the parties shall again go through the same selection process.

- (d) **Arbitrator Authority:** The arbitrator, and not any federal, state, or local court or agency, shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability or formation of this agreement including, but not limited to, any claim that all or any part of this agreement is void or voidable.
- (1) **At any time, the arbitrator will have the authority to consider and grant motions consistent with the Texas Rules of Civil Procedure (or Federal Rules of Civil Procedure, if applicable), including, but not limited to, motions for summary judgment.**
 - (2) The arbitrator is authorized only to rule on the claims set forth in the original written notice, any counterclaim(s), and the answer(s) made to such claims and counterclaims. The arbitrator is not authorized to modify the powers granted to him or her under this Policy or to make any award merely on the basis of what he or she determined to be just or fair.
 - (3) **The arbitrator shall also not commingle the standards for state law determinations and remedies (for example negligence claims and special damage awards) with the standards for federal law determinations and remedies that may or may not be subject to this Policy (for example, ERISA benefit eligibility and ERISA damage awards are not subject to arbitration).**
- (e) **Arbitration Procedures:** Any arbitration under this Section will be administered by a nationally recognized arbitration firm approved by the Company.
- (1) **Preliminary Hearing:** After arbitrator selection, a preliminary hearing may be scheduled upon request by the parties, the arbitration firm or the selected arbitrator. At this hearing, the arbitrator will work with the parties to narrow the issues, establish a discovery schedule, arrange for an acceptable procedure for the filing of any motions and arrange for the earliest and most efficient arbitration hearing possible for the issues in dispute.
 - (2) **Discovery:** The arbitrator will have discretion to order pre-hearing exchange of information, including but not limited to, document production, information requests, depositions, subpoenas, and summaries of expected testimony. The arbitrator can issue protective orders as he or she deems necessary or appropriate to protect the privacy or other legal rights of the parties and/or witnesses.
 - (3) **Recording the Hearing:** Either party may arrange for, and pay the cost of, a court reporter to provide a stenographic record of the proceedings. Otherwise, the arbitration hearing will not be recorded.
 - (4) **Attorney Fees:** Each party shall be responsible for their own attorney's fees, if any. However, if any party prevails on a statutory claim which allows the prevailing party to be awarded attorney's fees, or if there is a written agreement providing for such fees, the arbitrator may award reasonable attorney's fees to the prevailing party.

- (5) **Other Arbitration Expenses:** Each party shall also be responsible for any costs for witnesses called, any costs to produce evidence requested by the other party, deposition costs, and transcripts. The Employer will pay fees and expenses charged by the arbitrator or the selected arbitration firm for the arbitration; however, the Associate may elect to pay up to one-half of these fees and expenses if requested.
- (6) **Failure to Attend:** If you or the Employer fail to attend a scheduled arbitration hearing without good cause (as determined by the arbitrator), any claim brought by the party failing to attend will be dismissed and cannot be pursued further.
- (f) **Arbitration Decision:** Unless the parties agree otherwise, the arbitrator will make a final and binding decision within 30 days after the hearing is closed. The final decision and the arbitration award, if any, shall be made consistent with the remedies available under the state or federal statute, common law, code or regulation that is the subject of the claim. Judgment on any award by the arbitrator may be entered into any court having jurisdiction over the claim and shall have the same legally binding effect as if the judgment had been rendered in such court.
 - (1) **The arbitrator's decision shall be rendered in writing and include a brief summary of all findings of fact and conclusions of law necessary to support the arbitrator's decision.**
 - (2) The arbitrator shall assess the filing fee, arbitrator fees and expenses, and attorney's fees against a party upon a showing by the other party that the first party's claim is frivolous, or unreasonable, or factually or legally groundless.
 - (3) Except with respect to lawsuits or other proceedings seeking to enforce or vacate an arbitration award, all decisions rendered by an arbitrator under this Policy will be kept confidential by all parties. An arbitrator's decision shall not serve as binding, legal precedent with respect to subsequent claims or disputes under this Policy.
 - (4) **An arbitrator's decision can be challenged in a state or federal court of law only on such basis as are available under the Federal Arbitration Act.**

ADDITIONAL INFORMATION

- (a) **Interstate Commerce and Venue:** The Employer is engaged in transactions involving interstate commerce (for example, purchasing goods and services from outside Texas which are shipped to Texas, and traveling on interstate roadways) and the Associate's employment involves such commerce. The Federal Arbitration Act shall govern the interpretation, enforcement, and proceedings under the dispute resolution provisions of this Policy. Unless contrary to applicable law, any lawsuits seeking to enforce or vacate an arbitration award shall be brought in the United States District Court for the Northern District of Texas, Dallas Division.
- (b) **Binding Effect:** This Policy for resolving claims by arbitration is equally binding upon, and applies to any such claims that may be brought by, an Employer and each Associate and his/her spouse, children, parents, beneficiaries, Representatives,

executors, administrators, guardians, heirs or assigns (including, but not limited to, any survival or wrongful-death claim). This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute.

- (1) This Policy applies to each Associate and the Employer without regard to whether they have completed and signed a Receipt, Safety Pledge and Dispute Resolution Acknowledgement form or similar written receipt. Adequate consideration for this Policy is represented by, among other things, eligibility for (and not necessarily any receipt of) benefits under this Plan and the fact that it is mutually binding on both the Employer and Associates. Any actual payment of benefits under this Plan to or with respect to an Associate shall serve as further consideration for and represent the further agreement of such Associate to the provisions of this Policy. This Policy shall remain in effect with respect to the Employer and all Associates, without regard to any Associate refusal of benefits under this Plan, return of benefit payments under this Plan to an Employer, ineligibility for or cessation of benefits under this Plan in accordance with its terms, or any voluntary or involuntary termination of an Associate's employment with an Employer.
 - (2) This Policy is not subject to ERISA requirements or otherwise dependent upon the benefit provisions of this Plan in any way, and is included herein strictly as a matter of convenience in documentation. This Plan and Policy also in no way changes the "at will" employment status of any Associate not covered by a collective bargaining agreement.
 - (3) **If either party initiates a claim covered by this Policy by any means other than arbitration, the responding party shall be entitled to dismissal of such action, and the recovery of all costs and attorney's fees and expenses related to such action.**
- (c) **Amendment or Termination of Dispute Resolution Policy:** The Company shall have the right and power at any time and from time to time to amend this Policy, in whole or in part, on behalf of Employer, and at any time to terminate this Policy or any Employer's participation hereunder; provided, however, that no such amendment or termination shall alter the dispute resolution requirements of this Policy with respect to an Injury occurring prior to the date of such amendment or termination. In addition, any such amendment or termination of this dispute resolution Policy shall not be effective until at least 14 days after written notice has been provided to Associates. Any such amendment or termination shall be pursuant to formal written action of a representative authorized to act on behalf of the Company.
- (d) **Severability.** If one or more of the provisions in this Policy are deemed void by law, then the remaining provisions will continue in full force and effect.

APPENDIX B

NON-PARTICIPATING EMPLOYERS

The following employers **do not** participate in the Sysco Injury Protection Plan.

Sysco Louisiana Seafood, LLC
4410 West 12th Street
Houston, TX, 77055

European Imports, Inc.
1001 Santerre St.
Grand Prairie, TX 75050

Sysco Guest Supply, LLC
4010 Distribution Dr., #100
Garland, TX 75041

Este folleto y este formulario contienen información importante sobre sus derechos. Al dorso de este formulario encontrará la información en español. Si tiene dificultad en entender cualquier parte de este folleto, comuníquese con el Departamento de Manejo de Riesgo, Risk Management Department, al (281) 584-1390.

APPENDIX C

RECEIPT, SAFETY PLEDGE AND DISPUTE RESOLUTION ACKNOWLEDGEMENT

RECEIPT OF MATERIALS. By my signature below, I acknowledge that I have received and read (or had the opportunity to read) the Summary Plan Description (the "SPD") for the Sysco Injury Protection Plan, updated effective March 1, 2014.

INJURY NOTICE AND MEDICAL PROVIDERS. I understand and agree that if I am injured on the job, I must notify my Supervisor, Safety Manager, Human Resources Manager, Risk Management Manager or Health Services by the end of my workshift for the date of the Injury and receive any medical care from a Plan-approved physician within 14 days of my injury in order to receive benefits under the Plan.

SAFETY PLEDGE. I agree to familiarize myself with the safety program for the Employer and to perform my job according to the general and departmental safety rules of the Employer. I will also use any personal protective equipment that is provided to me. I also agree to immediately report to my supervisor any accident that involves another associates, a customer, a vendor, or me. I will also immediately report any unsafe act, condition or equipment. I will also cooperate with any accident investigations, and actively participate in any Employer safety training programs.

ARBITRATION. I also acknowledge that this SPD includes a mandatory company policy requiring that **claims or disputes relating to the cause of an on-the-job injury (that cannot otherwise be resolved between the Employer and me) must be submitted to an arbitrator**, rather than a judge and jury in court. I understand that by receiving this SPD and becoming employed (or continuing my employment) with the Employer at any time on or after March 1, 2014, I am accepting and agreeing to comply with these dispute resolution requirements. I understand that the Employer is also accepting and agreeing to comply with these dispute resolution requirements. All covered claims brought by my spouse, children, parents, beneficiaries, Representatives, executors, administrators, guardians, heirs or assigns are also subject to the Employer's dispute resolution policy, and any decision of an arbitrator will be final and binding on such persons and the Employer. **I understand that the arbitrator, and not a judge or jury, has the exclusive authority to resolve any dispute about the enforceability of this dispute resolution process.**

X _____ Associate's Signature	_____ Date
_____ Print Associate's Name	_____ Associate's Identification Number
_____ Parent or Legal Guardian Signature (if Associate under age 18)	_____ Date
_____ Print Parent or Legal Guardian Name	_____ Associate's Work Location or Department

APÉNDICE C

RECIBO, COMPROMISO DE SEGURIDAD Y ADMISIÓN DE RESOLUCIÓN DE CONFLICTOS

RECIBO DE MATERIALES. Con mi firma a continuación, acepto que recibí y leí (o tuve la oportunidad de leer) la Descripción Resumida del Plan (*Summary Plan Description*, "SPD") del Sysco Injury Protection Plan actualizado, vigente a partir del 1.º de marzo de 2014.

AVISO DE LESIÓN Y PROVEEDORES MÉDICOS. Entiendo y acepto que si sufro una lesión en el trabajo, para recibir los beneficios conforme al Plan, debo notificar a mi supervisor, gerente de Seguridad, gerente de Recursos Humanos, gerente de Manejo de Riesgo o de Servicios de Salud al finalizar mi turno de trabajo de la fecha de la lesión y recibir atención médica de un médico aprobado por el Plan en un plazo de 14 días a partir de mi lesión.

COMPROMISO DE SEGURIDAD. Acepto familiarizarme con el programa de seguridad del Empleador y desempeñar mi trabajo según las reglas de seguridad generales y departamentales del Empleador. También usaré todo equipo de protección personal que se me proporcione. Además, acepto informar inmediatamente a mi supervisor sobre cualquier accidente que involucre a otro asociado, a un cliente, a un proveedor o a mí. Asimismo, informaré de inmediato sobre cualquier acción, condición o equipo inseguros. Por último, cooperaré con cualquier investigación de accidentes y participaré activamente en cualquier programa de capacitación de seguridad del Empleador.

ARBITRAJE. También reconozco que esta SPD incluye una política obligatoria de la compañía que requiere que **los reclamos o conflictos relacionados con la causa de una lesión en el trabajo (que no puedan resolverse de otro modo entre el Empleador y yo) deben ser presentados ante un árbitro**, en lugar de un juez y jurado en un tribunal. Entiendo que al recibir esta SPD y al pasar a ser empleado (o continuar en mi empleo) del Empleador en cualquier momento a partir del 1.º de marzo de 2014 o posteriormente, acepto y acuerdo cumplir estos requisitos de resolución de conflictos. Entiendo que el Empleador también acepta y acuerda cumplir estos requisitos de resolución de conflictos. Todos los reclamos cubiertos presentados por mi cónyuge, mis hijos, mis padres, mis beneficiarios, mis Representantes, mis ejecutores, mis administradores, mis tutores, mis herederos o mis cesionarios también están sujetos a la política de resolución de conflictos del Empleador, y cualquier decisión de un árbitro será definitiva y vinculante para dichas personas y el Empleador. **Entiendo que el árbitro, y no el juez ni el jurado, tiene la autoridad exclusiva para resolver cualquier conflicto sobre exigibilidad de este proceso de resolución de conflictos.**

X _____ Firma del Asociado	_____ Fecha
_____ Nombre del Asociado en Letra de Imprenta	_____ Número de Identificación del Asociado
_____ Firma del Padre, de la Madre o del Tutor Legal (si el Asociado es menor de 18 años)	_____ Fecha
_____ Nombre del Padre, de la Madre o del Tutor Legal en Letra de Imprenta	_____ Lugar de Trabajo o Departamento del Asociado

Este folleto y este formulario contienen información importante sobre sus derechos. Al dorso de este formulario encontrará la información en español. Si tiene dificultad en entender cualquier parte de este folleto, comuníquese con el Departamento de Manejo de Riesgo, Risk Management Department, al (281) 584-1390.

Sign and Turn In

RECEIPT, SAFETY PLEDGE AND DISPUTE RESOLUTION ACKNOWLEDGEMENT

RECEIPT OF MATERIALS. By my signature below, I acknowledge that I have received and read (or had the opportunity to read) the Summary Plan Description (the "SPD") for the Sysco Injury Protection Plan, updated effective March 1, 2014.

INJURY NOTICE AND MEDICAL PROVIDERS. I understand and agree that if I am injured on the job, I must notify Supervisor, Safety Manager, Human Resources Manager, Risk Management Manager or Health Services by the end of my workshift for the date of the Injury and receive any medical care from a Plan-approved physician within 14 days of my injury in order to receive benefits under the Plan.

SAFETY PLEDGE. I agree to familiarize myself with the safety program for the Employer and to perform my job according to the general and departmental safety rules of the Employer. I will also use any personal protective equipment that is provided to me. I also agree to immediately report to my supervisor any accident that involves another associate, a customer, a vendor, or me. I will also immediately report any unsafe act, condition or equipment. I will also cooperate with any accident investigations, and actively participate in any Employer safety training programs.

ARBITRATION. I also acknowledge that this SPD includes a mandatory company policy requiring that **claims or disputes relating to the cause of an on-the-job injury (that cannot otherwise be resolved between the Employer and me) must be submitted to an arbitrator**, rather than a judge and jury in court. I understand that by receiving this SPD and becoming employed (or continuing my employment) with the Employer at any time on or after March 1, 2014, I am accepting and agreeing to comply with these dispute resolution requirements. I understand that the Employer is also accepting and agreeing to comply with these dispute resolution requirements. All covered claims brought by my spouse, children, parents, beneficiaries, Representatives, executors, administrators, guardians, heirs or assigns are also subject to the Employer's dispute resolution policy, and any decision of an arbitrator will be final and binding on such persons and the Employer. **I understand that the arbitrator, and not a judge or jury, has the exclusive authority to resolve any dispute about the enforceability of this dispute resolution process.**

X _____ Associate's Signature	_____ Date
_____ Print Associate's Name	_____ Associate's Identification Number
_____ Parent or Legal Guardian Signature (if Associate under age 18)	_____ Date
_____ Print Parent or Legal Guardian Name	_____ Associate's Work Location or Department

RECIBO, COMPROMISO DE SEGURIDAD Y ADMISIÓN DE RESOLUCIÓN DE CONFLICTOS

RECIBO DE MATERIALES. Con mi firma a continuación, acepto que recibí y leí (o tuve la oportunidad de leer) la Descripción Resumida del Plan (*Summary Plan Description*, "SPD") del Sysco Injury Protection Plan actualizado, vigente a partir del 1.º de marzo de 2014.

AVISO DE LESIÓN Y PROVEEDORES MÉDICOS. Entiendo y acepto que si sufro una lesión en el trabajo, para recibir los beneficios conforme al Plan, debo notificar a mi supervisor, gerente de Seguridad, gerente de Recursos Humanos, gerente de Manejo de Riesgo o de Servicios de Salud al finalizar mi turno de trabajo de la fecha de la lesión y recibir atención médica de un médico aprobado por el Plan en un plazo de 14 días a partir de mi lesión.

COMPROMISO DE SEGURIDAD. Acepto familiarizarme con el programa de seguridad del Empleador y desempeñar mi trabajo según las reglas de seguridad generales y departamentales del Empleador. También usaré todo equipo de protección personal que se me proporcione. Además, acepto informar inmediatamente a mi supervisor sobre cualquier accidente que involucre a otro asociado, a un cliente, a un proveedor o a mí. Asimismo, informaré de inmediato sobre cualquier acción, condición o equipo inseguros. Por último, cooperaré con cualquier investigación de accidentes y participaré activamente en cualquier programa de capacitación de seguridad del Empleador.

ARBITRAJE. También reconozco que esta SPD incluye una política obligatoria de la compañía que requiere que **los reclamos o conflictos relacionados con la causa de una lesión en el trabajo (que no puedan resolverse de otro modo entre el Empleador y yo) deben ser presentados ante un árbitro**, en lugar de un juez y jurado en un tribunal. Entiendo que al recibir esta SPD y al pasar a ser empleado (o continuar en mi empleo) del Empleador en cualquier momento a partir del 1.º de marzo de 2014 o posteriormente, acepto y acuerdo cumplir estos requisitos de resolución de conflictos. Entiendo que el Empleador también acepta y acuerda cumplir estos requisitos de resolución de conflictos. Todos los reclamos cubiertos presentados por mi cónyuge, mis hijos, mis padres, mis beneficiarios, mis Representantes, mis ejecutores, mis administradores, mis tutores, mis herederos o mis cesionarios también están sujetos a la política de resolución de conflictos del Empleador, y cualquier decisión de un árbitro será definitiva y vinculante para dichas personas y el Empleador. **Entiendo que el árbitro, y no el juez ni el jurado, tiene la autoridad exclusiva para resolver cualquier conflicto sobre exigibilidad de este proceso de resolución de conflictos.**

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